REVIEW OF LITERATURE

TEENAGE HEALTH STATUS: DIFFERENT PERSPECTIVES

Lifestyle, Health Habits and Teenage Health

The teenagers in 21st century are proving the prediction of Heaven (1996) to be truer than before that they are at greater risk of leading an unhealthy lifestyle. Some behaviours appear quite commonplace, are taken for granted, and are not associated with risk. These include hours of passive television watching or the consumption of large quantities of fast foods, or the practice in some communities of introducing teenagers to alcohol at a relatively young age. But, these and many more are dangerously poised.

The Concept of Lifestyle

According to Bruhn (1988), lifestyle refers to an individual's 'philosophy of life' and usually incorporates one's values, beliefs, attitudes, and behaviours. One can acquire a lifestyle in all sorts of different ways: by watching and learning from others through information provided by different media, and through life changes. For instance, parents who smoke cigarettes or drink alcohol or eat unhealthy food are likely to instill similar values or behaviours in their children who will come to view such behaviour as acceptable. Or it is possible that a glossy advertisement in which cigarette smoking is linked to a glamorous lifestyle might entice someone to begin smoking.

It is possible to list several illness lifestyles (Bruhn, 1988). To mention just a few these may include the following: minimal self-care activities, risk-seeking health behaviour, external locus of control, low self-esteem, as well as the perception that one's behaviour is difficult to change or that change itself is not worth it. It is possible that an
individual who puts his or her health at risk may manifest one (but rarely all) of the lifestyles listed above.

According to Argyle (1997), lifestyle is the most obvious correlate of health. Health is better for those who drink and smoke less, take exercise and eat the right food, although it is less obvious why they do it. Lifestyle is one of the main explanations for the shorter lives of men; that they drink and smoke and have unhealthy habits is established and maintained. This is partly a matter of social skills; only those who are sufficiently rewarding and cooperative are able to find adequate social support.

**Health, Leisure, Physical Activity and Happiness**

Argyle (1997) argued that some kinds of leisure is good for health. Sport and exercise give the greatest benefits. Exercise has been found to have widespread benefits for health, including heightened immune function. It also reduces the effect of stress on health (Argyle, 1996).

Turning to more permanent states of happiness, serious leisure, such as hobbies and leisure groups with a particular purpose, is a major contributor. Argyle (1997) found that people who have committed forms of leisure feel more challenged and stressed, but have more leisure satisfaction and are happier than those who do not. Some other studies however have found that most people prefer to be challenged less in their leisure time (Argyle, 1996).

In India, Quraishi (2002) opined that as a result of the spread of mass education in Asian countries, the number of adolescents and the youth in school and college campuses has been steadily increasing.

The emotional control of family, the moral control of school and the social control mechanism of community have been showing signs of decline. Transition from childhood to adulthood, consequently, is no longer as smooth as it used to be. Younger people are no long absorbed into adulthood under the tutelage of elders. Increased
autonomy and freedom of personal choices draw impressionable young students towards risk taking experiments during these fluid years full of psycho-biological changes.

According to Quarishi (2002) the category most vulnerable to wrong life-style is the adolescents because of their risk taking behaviour. Consequently, the average age of drug users has been getting lower all over the world. In India, the rate of prevalence of drug abuse which is generally low in early adolescence (ages 12 and 13), rises steeply in the late teenage and is the highest during the early twenties. This is the period when most of the young people are in the universities and colleges and hence require special attention. In India, injecting drug users are mostly the young people who have emerged as one of the most risk prone categories of HIV/AIDS infection. Similarly, alcoholism has also emerged as a major socio-medical problem among the young exposing them to accident, suicidal behaviour, high risk sexual practices. Smoking, to which many young people are attracted, has become another great killer habit. Further, a majority of sexually transmitted diseases that occur in the world are in the age group of 15-21 years. In India, out of the current 13 million STD patients, the majority acquired the disease during the period of their adolescence and early childhood. In fact research has shown that most of the health problems of the adult and the aged are consequences of risk taking behaviour during the period of youth.

Quraishi (2002) said that since the educational curriculum is seldom related to these issues, these can be taken up through innovative co-curricular programmes.

**Health Habits and Teenage Health Status**

Heaven (1996) listed some of the psychological benefits that flow from physical fitness. These include such features as feeling more positive about oneself, reducing depression, helping to reduce hostile behaviour in oneself and so forth. Thus, as Harris (1991) has argued, there are many benefits to being physically active. Indeed, she stresses
that one cannot afford not to exercise. It is as though physical exercise remains the only constant factor in the teenager’s world, which is subject to biological, emotional, and cognitive change. Regular exercise also has some discernible physical benefits.

Psychological benefits of regular physical activity are numerous like it acts as an energizing force, relieves from tension and anxiety, helps to strengthen the body’s ability to cope with stress, counteracts hostile behaviour, helps clean the mind – improves concentration and memory, encourages a positive self-image and helps improve self-confidence, contributes to feelings of exhilaration and physical wellbeing, helps improve sleeping patterns and helps alleviate depression and anxiety.

**Diet and Health Status**

Heaven (1996) said that there is at least one compelling reason for adolescents to maintain a healthy and balanced diet and that is because of the growth spurt. There are gender differences, however, with boys tending to gain more muscle than girls who, in turn, gain more fat.

Heaven (1996) further stated that teenagers perceive certain barriers to improving their nutrient intake. These are lack of time, the view that eating properly is inconvenient, and the lack of a sense of urgency. As regards attitude formation toward diet and nutritional issues, teenagers absorb parental values about a wide range of important health issues and so family experience is vital. Interestingly, some evidence suggests that this might be the case for males, but not for females.

More recently, strong arguments have been made about the important effects that television programmes and advertisements have in shaping attitudes toward health issues as well as health behaviours. Wallack and Dorfman (1992) noted that those individuals who watched more television were more likely to believe in the healing powers of medication than adopting healthy behaviours.
Health Protective Behaviour and Health Risk Behaviour in Teenagers

It is common knowledge that adolescence is a time of risk taking. It is well established, statistically, that adolescents experience the negative consequences of some risk behaviours to a disproportionately high degree (Quadrel et al., 1993).

Harrison et al., (2001) reported that reducing morbidity and mortality among teenagers depends on early recognition and identification of health risks, most of which derive from social factors. In fact, the 15 to 24 years age group is the only group in the United States for which the top three causes of death (accidents, homicide, and suicide) are all behaviour-related; combined, they account for 75% of deaths, as well as 51% of deaths in the 5 to 14 years age group. Substance abuse is believed to be a contributing factor in many adolescent deaths from unintentional or intentional injury.

According to Harrison et al (2001), survey of health risks among adolescents revealed that substance abuse, unhealthy weight, violence, problems at school (truancy, academic aspirations, emotional distress and suicidal tendencies were the most prominent ones.

Many researchers have suggested that substance use and abuse form an important part of the lives of most teenagers and that many will experiment with substances such as alcohol and cigarettes (Heaven, 1996). Moreover, not only do these substances have a potentially harmful effect on one’s health, but they have also been shown to be implicated in a variety of risky and anti-social behaviours such as violent and non-violent crime, delinquency, and sexual promiscuity. In this light, therefore, substance abuse by teenagers takes on added significance.

More recently, Kandel and Yamaguchi (1993) confirmed that a drug such as crack is initiated after experience with marijuana. Moreover, important gender differences in the developmental
progression of involvement with drugs were noted. Cigarettes were found to precede marijuana use among females, while alcohol use preceded marijuana use for males (even in the absence of cigarette usage). Cigarette smoking was found to be an important pathway to illicit drugs other than marijuana for males.

According to Quadrel et al., (1993), a ready explanation for why adolescents take risks is that they ignore, or at least greatly underestimate, the likelihood of bad outcomes. A popular account of such underestimation is that teenagers see themselves as invulnerable to those threats. As a result, they focus just on the benefits of risk behaviours. Some variant of this “adolescent invulnerability hypothesis” appears in many writings on adolescence.

Because health-enhancing behaviours, such as healthy eating habits, regular exercise, adequate sleep, dental care, and safety practices, are advocated, encouraged, and supported by the various institutions of conventional society – the family, schools, and church – engagement in them can reflect adherence to the norms of conventional society (Jessor et al., 1998).

Health Protective behaviour

Kasl and Cobb (1996) defined health behaviour as any activity undertaken by a person believing himself to be healthy for the purpose of preventing disease or detecting it at an asymptomatic stage. This definition is, of course, very much influenced by a medical perspective. One might also wish to include behaviours that increase health in the sense that they may make one fitter, stronger or more attractive. An alternate approach that does not focus on medically approved health behavior has been proposed by Harris and Guten (1979). They assumed that all individuals engage in some behaviours intended to protect their health, medically sanctioned or not or objectively effective or not. Harris and Guten identified these behaviors, their relation to actual health status. These activities were termed health protective
behavior (HPB) and defined as “any behavior performed by a person, regardless of his or her perceived or actual health status, in order to protect, promote, or maintain his or her health, whether or not such behavior is objectively effective toward that end”.

Harris and Guten (1979) conducted an exploratory study using 1,250 randomly chosen residents in the Greater Cleveland area. The three sets of variables assessed included health protective behaviour, health condition, and health belief model variables.

The cluster analysis indicated five clusters of health protective behaviour named by these investigators as (1) health practices - sleeping enough, relaxing, eating sensibly, exercising in moderation, avoiding overwork, avoiding chills, limiting certain food, and watching weight; (2) safety practices - repairing things, checking the condition of the things, having a first - aid kit, and posting emergency phone numbers; (3) preventive health care - physical and dental checkups; (4) environmental hazard avoidance - avoiding areas of crime and population ; and (5) harmful substance avoidance - no smoking or drinking. In terms of good versus poor health, the results suggest that health protective behaviour does not vary substantially by health condition. In general, those individuals classified as being in good, moderate or poor health did not display considerable differences in health protective behaviour.

One acts to promote health by getting enough sleep, eating a balanced diet, and to avoid ill health by not smoking or practicing safe sex. One uses seat belts and crash helmets and teaches one's children to cross roads safely. People take up offers of cervical screening and have their babies immunized. People also practice health habits that they are scarcely aware of , such as washing hands, or brushing teeth. People try to avoid exposure to pollutants such as cigarette smoke or addition in food. Adolescents may also be using similar health enhancing behaviours.
The conceptual role of protective factors is to increase the likelihood of desirable or positive behaviors or outcomes of diverse life areas, including health and well-being, and also as buffer or moderate of the negative influence of exposure to risk. Two categories of protective factors in health were examined by Jessor et al., (1998). The first category consisted of those protective factors that are health-specific, that is, they are variables proximal to, and directly implicating, health. Such health-specific protective factors include persona orientation towards and commitment to health (e.g., parental and peer models for health locus of control) and perceived social support for engaging in health behaviors (e.g., parental and peer models for health-enhancing behavior). The second category of protective factors consisted of psychosocial variables that are distal from health, that is, variables that do not have any direct reference to health or any obvious or immediate implication for health-enhancing behavior. Nevertheless, they also can serve a protective function. The category of distal protective factors includes personality, perceived social environment, and behavior variables that reflect an orientation toward and involvement with the conventional institutions of family, school and church (e.g., religiosity, positive relations with adults, and participation in prosocial activities such as family activities, school clubs, and volunteer work).

The psychosocial risk and protective factors used in the study by Jessor et al., (1998) provided a substantial cumulative account of variation in health – enhancing behavior – 39% of the variance after the influence of sociodemographic characteristics had been taken into account, with respect to both risk and protection. Individual differences in personality and in characteristics of the perceived social environment were shone to be relevant to health behavior in adolescent.

Protective factors accounted for substantial variance in health – enhancing behavior in adolescence, and with these measures, they
account for more unique variance (16%) than do the risk factor measures (2%). Jessor et al., (1998) further reported that other, more distal correlates of health behavior include self-efficacy and religiosity. These findings were derived from samples of college students and younger adolescents.

Bray et al., (2001) conducted a prospective, school-based study of increasing alcohol use in a multi-ethnic sample of seven thousand five hundred and forty adolescents and found that the effects of stress, family conflict, and parental monitoring were differentially moderated by two modes of individuation. The effects of stress were moderated by status and individuation.

Harrison et al., (2001) studied Adolescent Health Behavior and concluded that all behaviors were on high, moderate and no risk level. The risk areas which were high were sexual activity, alcohol use, substance abuse/dependence and physical or sexual abuse. Moderate risk behaviours were lack of exercise, family interaction problems, problem at school, emotional distress, suicidal behavior, cigarette smoking and marijuana use. The behaviors which were reported to be at no risk level were poor nutrition, unhealthy weight control and violent behaviour.

Kim (2001) explored the negative health behaviours of Korean adolescents, including factors affecting their negative health behaviors, and presented a substantial correlation model between the negative health behaviors and psychological factors. Two thousand one hundred and twenty four adolescents (aged 14-18 years) randomly selected from junior high and high schools in Seoul were surveyed. Four Korean-version instruments were used to identify negative health behaviors and psychological constructs : Adolescent Health Survey, Health Locus of Control scale, Self-esteem Scale, and Self-efficacy Scale. The subjects had a high prevalence of smoking, alcohol drinking, bad eating habits, and pornography viewing, but a very low prevalence of sexual
intercourse and illegal drug use. Health Locus of Control was significantly correlated with lack of exercise, illegal drug use, alcohol use, and smoking. Self-esteem were substantially correlated with eating problems, illegal drug use, lack of exercise, pornography viewing, and alcohol use were also statistically correlated with self-efficacy.

Harris et al., (2002) examined the extent to which adolescents' expectations about their future in terms of health and education affected their risk taking behaviour. With data from the National Logitudinal Study of Adolescent Health, the authors tested the theory that a "nothing to lose" attitude about the future predicted greater involvement in risk behaviors involving early sexual intercourse, selling drugs, and weapon use. Ten thousand and one hundred and twenty two adolescents aged 13-18 provided data during in-school interviews. The authors examined the effects of both individual and school-level conditions. Results provided mixed support for authors' "nothing to lose" hypothesis. Results found noteworthy school-level effects of "school climate", including aggregate expectations, mental health, and the prevalence of single-mother families, that influenced adolescence risk-taking behaviour more than school measures of socio-economic status.

MacDonald and Wright (2002) reported that the consequence of smoking for women are of particular concern in the light of recent observations, that more adolescent females than males are taking up smoking. They explored gender differences in the relationships between cigarette smoking and adolescents' experiences of school climate and their relationships with the school and significant adults in their lives using a data set derived from a student survey conducted in 2002. Adolescent girls who smoked were more likely than either males or nonsmoking females to experience powerlessness in their school environment and felt considerably less attachment to the school. Female smokers were more likely than male or female nonsmokers to be
engaged in oppositional, distanced, and unsatisfactory relationships with important adults in their lives, particularly those who were in positions of relative power and authority.

Griffin et al., (2002) opined that several studies have investigated the relationship between psychological distress and substance use among youth. However, less research has investigated the potentially protective role of psychological well-being on adolescent substance use, and the extent of which personal competence skills may promote well-being. Griffin et al., (2002) examined personal competence skills, psychological distress and well-being, and adolescent substance use over a 3 year period in a predominantly minority sample of 1,184 urban students (60% females and 40% male) attending 13 junior high schools in New York City. Structural equation modeling indicated that greater competence skills predicted less distress and greater well-being over time. Although psychological well-being was associated with less subsequent substance use, distress did not predict later substance use. Findings indicated that competence skills promoted resilience against early stage substance use in part by enhancing psychological well-being, and suggested that school-based prevention programmes should include competence enhancement components in order to promote resilience.

Perception of Health Status by Teenagers

According to Millstein et al., (1993) the accuracy with which teenagers perceive their health status has been viewed in contradictory terms. On the one hand, teenagers are seen as minimizing their symptoms through denial and failing to respond to symptoms appropriately. On the other hand, they are also viewed as exaggerating and dwelling on symptoms due to greater self-consciousness, introspection and attention to body states.

While teenagers generally report themselves as being healthy, they view their health as being poorer than do physicians who examine
them or their parents. It is not clear whether the differences that emerge are a function of heightened self-consciousness in teenagers or whether they reflect differences in how teenagers and adults define good health.

**MENTAL HEALTH** is aptly defined as the full and harmonious functioning of the total personality, realizing one’s full potential in the world of work, with satisfaction and contentment to oneself and benefit to the society (Verma, 1998).

Verma (1998) put forth a dual factor theory of mental health. This dual factor theory postulates that there are different sets of factors that contribute to negative and positive mental health. Some factors when present only contribute to negative mental health but their absence does not lead to positive mental health. These negative factors could be manifested as mental disorders (like neurosis, psychoses, drug and alcohol dependence, personality disorders, psychophysiological disorders, etc.) or as mental symptoms (like anxiety, depression, obsessions, compulsions, phobias, delusions, hallucinations, derealization, depersonalization, etc.) or even as negative states (like anger, hostility, dissatisfaction, jealousy, irritability, fear, prejudices, inferiority feelings, loneliness, hate, anxiety, depression, etc.).

It is customary to talk of the dual factor theory of mental health—the negative mental health (freedom from mental disorders) and the positive mental health (factors directly contributing to mental health). Verma (1987) opined that for obvious reasons, the negative mental health has to be attended to first as it is more distressing and disabling.

Millstein et. al. (1993) opined that positive mental health includes both subjective and objective components. The subjective components of positive mental health identified by mental health professionals and behavioural scientists have centered on cognitive and affective factors, including an affective experience of subjective well-being or personal happiness, belief in one’s personal competence or efficacy in achievement contexts (work and school), a sense of personal control or
autonomy, a sense of relatedness to others, and motivation to direct
behaviour toward personally relevant goals.

Millstein et al. (1993) said that a well adjusted teenager may be
more or less committed to certain domains of functioning, for example,

**Axis I: Coping with Stress and Adversity**
- Includes skills and motivation to manage acute, major life
  stressors and recurring daily stressors.
- Includes skills to solve problems (problem-focussed coping) and
  skills for emotion management (emotion-focused coping)
- Effectiveness is characterized by flexibility and the ability to meet
  the demands of varying types of stress.

**Axis II: Involvement in Personally Meaningful Activities**
- Includes skills and motivation to engage in instrumental and/or
  expressive activities that are personally meaningful.
- Includes behaviours and activities that are experienced as
  autonomous and self-determined.

**Axis III: Perspectives of Interested Parties**
- Includes the perspectives of adolescents, parents, teachers, and
  mental health professionals.
- Adolescents emphasize subjective well-being.
- Societal agents (parents, teachers) emphasize behavioural
  stability, predictability, and conformity to social rules.
- Mental health professionals emphasize specified theories of
  personality or human behaviour.

**Axis IV: Development Factors**
- Adolescents development is viewed in light of pervious
  development during childhood and subsequent development
  during adulthood.
- Development changes during adolescence in cognitive, affective,
  social and biological functioning.
- Cohort differences in events and social contexts affect the
  development of positive mental health.
**Axis V: Sociocultural Factors**

- Sociocultural differences in values regarding optimal development and functioning during adolescence.
- Sociocultural differences in perceived threats to positive mental health and the risk of maladjustment.

As a whole, positive adolescent mental health is likely to be characterized by feelings of competence and positive affect in domains and contexts that are important or meaningful to the individual. Additionally, Millstein et. al. (1993) reported that social competence, self-efficacy, ability and motivation to involve oneself in meaningful activities are some common indices of positive mental health during adolescence.

Based on this framework, positive mental health during adolescence is defined as **process characterized by development towards optimal current and future functioning in the capacity and motivation to cope with stress and to involve the self in personally meaningful instrumental activities and/or interpersonal relationships.** Optimal functioning is relative and depends on the goals and values of the interested parties, appropriate developmental norms, and one's sociocultural group. Based on multiaxial approach to positive mental health during adolescence, this construct cannot be characterized by a single profile or developmental trajectory (Powers et al., 1989). Rather, multiple different developmental paths during adolescence could represent adaptive functioning.

Psychologists' views of adolescence have been sufficiently negative that, for much of the past, a discussion of the nature of positive mental health during adolescence would have constituted a contradiction in terms. Adolescence was viewed as period of stress and storm in which psychopathology, personal distress, and behavioural destruction were considered to be the norm. Supposedly, Adolescence is characterized as self-focussed, depressed, rebellious, hostile, and
likely to be involved in deviant peer groups activities (Erikson, 1968; Freud, 1958; Hall, 1904). Currently, accumulation of considerable empirical data has led to substantial changes such that we now characterize adolescence in more positive terms as a developmental stage offering tremendous opportunities for growth and positive outcomes (Feldman and Ellion, 1990; Petersen, 1988; Powers et al., 1989).

Some mental health problems are common among teenagers. According to Heaven (1996) a number of teenagers suffer emotional and mental dysfunction. Of added importance is the fact that such turmoil is very often carried over into adulthood with serious implications for adjustment during the post-adolescent years.

Kazdin (2003) reported prevalence of different kinds of problem behaviours among teenagers. They are:

**Externalising disorders:** For example, disruptive behavioural problems that are directed towards the environment and others. Primary examples include oppositional, hyperactive, aggressive, and antisocial behaviors.

**Internalizing disorders** which are emotional problems that are directed toward inner experience. Primary examples include anxiety, withdrawal, depression.

**Substance-related disorders** which includes impairment associated with use of any of a variety of substances including alcohol, illicit drugs, and tobacco. These disorders, while important in their own right, are also associated with other psychiatric disorders.

**Learning and mental disabilities** include a range of problems related to intellectual and academic functioning including mental retardation and learning disorders. Such problems are probably underestimated, both in terms of prevalence and impact on behaviour, among children and adolescents referred to treatment because of the more salient problems that serve as the basis for referral.
Severe and pervasive psychopathology These problems include disorder that the recognized to be the more severe forms of psychology that have pervasive influences in the areas of functioning they affect and in their long-term course Examples include schizophrenia and autism.

Isberg et al (1989) reported that adolescents with mental health problems had significantly lower self-esteem than normal high school students.

Hallfors (2002) and Ray et al (2002) reported that mental health problems are clearly associated with substance use and mental health problems, although there is some controversy about the direction of this relationship. Retrospective epidemiological research from the National Comorbidity study found that mental health conditions preceded addictive disorders in 86% of cases and that both disorders usually occur first in teenage.

Williams et al (2002) reported mental health and physical health are perhaps more intimately entwined in adolescence than in any other developmental time period. The leading causes of mortality (reckless driving, homicide, and suicide) all have links to underlying psychopathology. Moreover, psychosocial factors related to psychopathology may influence physical morbidity directly through psychophysiological pathways and indirectly through health behaviour. With respect to health behaviour, social and emotional problems have been associated with a variety of negative health behaviours. For example, depression is reciprocally related to smoking in adolescence (Windle and Windle, 2001). Smoking, in turn, is related to a variety of short term health complications for adolescence such as respiratory tract infections and declines in physical fitness, in addition to long-term health problems in adulthood. Colder and Chassin (1999) reported that problem alcohol use is associated with fundamental family disruptions and poor psychological functioning, whereas moderate use is
associated with unconventionality and socialization processes specific to alcohol.

In a study conducted by Yeh (2003), the association between age, acculturation, cultural adjustment difficulties and general mental health concerns were investigated. It was found that age, acculturation, and cultural adjustment difficulties had significant predictive affects on mental health symptoms.

According to Biner (2002) teenagers are at risk for anti-social behaviour because of mental health problems.

Farmer, et al. (2003) examined incidence of mental health problems among children and teenagers. Population estimates indicated that 54% of use had used mental health services.

Passmore and French (2000); Barber et al (2001) and Barho and Eccles (2003) reported that prosocial activities, participation in organised, relaxed leisure activities predicted lower substance abuse, higher self-esteem and positive mental health among teenagers.

This study is poised to view teenage/adolescence as a period of problems and promises.
PERSONALITY AND TEENAGE HEALTH

Definitions Of Personality Dimensions

Personality has been recognized as a very important determiner of human behavior. The study of personality in health has a long history (Friedman, 1990). The term "personality" is a complex concept much older than the term psychology. From the ancient days, civilized people have tried to develop an insight into the nature of man. Personality as a concept has been defined in so many ways.

Paul et al., (1996) said that personality is defined in terms of individual differences in enduring and characteristic ways of thinking, feeling, and acting. As Allport and Odbert (1936) showed, the English language has thousands of trait-names for these differences (e.g. insecure, fun-loving, imaginative, generous, hardworking), and hundreds of scales and inventories have been developed by personality psychologists to measure proposed traits, types, needs, and temperaments.

Personality has been studied in a number of different ways. Some have developed broad theories to explain the origins and makeup of personality. Others have focused only on one or two issues, such as the influence of heredity on personality.

Cattell (1950) stated that “Personality is that which permits prediction of what a person will do in a given situation.” Eysenck (1968) proposed a definition of personality as “more or less stable and enduring organization of person’s character and temperament, intellect and physique which determines his unique adjustment to the environment. In their personality structure, some individuals possess “core” characteristics (either inherited or develop under influence of certain situations) which make them more vulnerable than others to certain kinds of human conflict which threaten their emotional security.
According to Morgan et al., (1993) Personality consists of the distinctive patterns of behaviour (which include thoughts and emotions) that characterize each individual’s adaptation to the situations of his or her life. Personality includes the behaviour patterns a person shows across situations or the psychological characteristics of the person that lead to those behaviour patterns (Morgan et al., 1993).

In the present study teenage health was studied on relation to Eysenckian personality dimensions, Self Esteem, Health Locus of Control and Type A.

**Eysenck’s Personality Theory**

Eysenck on the basis of research and factor analysis (1947, 1960, 1963, 1967, 1970 and 1980) put forth a dimensional system of personality which posits three major independent dimensions viz. Extraversion/Introversion (E/I), Neuroticism/Stability (N) and Psychoticism (P). He also proposed a psychobiological model to parallel these three dimensions (Eysenck, 1967, 1981 and Eysenck and Eysenck 1985). The model is a hierarchical one which conceptualizes that each of the three broad dimensions are subdivided at a lower level into narrower and more specific traits.

Eysenck and Eysenck (1985) reported that each of these personality dimensions include certain subtraits. The subtraits or Extraversion were as follows: sociable, lively, active, assertive, sensation seeking, carefree, dominant, surgent and venturesome. The subtraits of Neuroticism were as follows: anxious, depressed, guilty, low self esteem, tense, irrational, shy, moody and emotional. The subtraits of Psychoticism were as follows; aggressive, cold, eccentric, impersonal, impulsive, antisocial, unempathic, creative, tough minded and refers to a person who does not fit in anywhere. In addition, the revised Eysenck personality Questionnaire (EPQ-R) also contains a Lie Scale (Social Desirability) which was first incorporated in Eysenck Personality Inventory (EPI) to
measure a tendency on the part of the subjects to fake ‘good’
responses. Now it measures an independent stable factor which
possibly denotes some degree of social naivette (Eysenck and Eysenck
1975). Using both the child and the adult versions of the EPQ, Eysenck
and Eysenck (1975) have shown that supertraits of Extraversion,
Neuroticism and Psychoticism are replicable across cultures. (Eysenck

Health Locus of Control

According to Smith et al., (1997) the Locus of Control construct
has generated enormous interest over the past 30 years. Locus of
control, as defined by Rotter (1966), refers to individual differences in
the extent to which people perceive events as contingent upon their
own behavior or enduring characteristics (a belief in internal control)
versus the extent to which they believe that reinforcement is contingent
not upon the self, but upon external factors such as chance, fate, or
powerful others (a belief in external control). By this definition, internally
perceived locus of control is similar to but not identical with agentic
traits. Internality has to do with control over events, whereas agency is
defined in terms of the performance of assertive or controlling
behaviors. One might thus be agentic without being internal, but it is
unlikely that persons who believe their capacity to internally control the
outcome of events will not also behave in agentic ways. One should
therefore expect internality to be higher among males. Smith et al.,
(1997) opined that males are expected to be higher on internality
than females.

Rotter (1966) postulated that an individual who perceives his or
her illness as consequence of one’s own behaviour is said to have
Internal locus of control. Such a person is likely to recover soon but an
External person tends to perceive his behavior as determined by
external events beyond his control; such as fate, powerful others etc.
This is negative expectancy and he/she is unlikely to progress and
recover from illness. Health psychologists like Wallston et al., (1987) expanded the original scale beyond Rotter's so-called simple internal-external dimension. Wallston et al., (1987) said that one's health status may be determined by health locus of control dimensions.

Wallston et al.’s (1987) Health Locus of Control Scale measures two dimensions of health locus of control viz. Health Locus of Control–Internal—the extent to which individual believes that his/her locus of control for health is internal.

Health Locus of Control—External—the extent to which individual believes that external factors like luck, chance, fate, are affecting his/her health.

There is a large body of research which has implicated Locus of Control in wide range of health behaviours and attitudes with internals engaging more in health promoting behaviours (Lau.,1988).

**Self-Esteem**

Self esteem is one of the most widely investigated individual differences dimensions in the field of Psychology. Self esteem can be defined as a personal judgement of general self-worth that is a product of an implicit evaluation of self-approval or self-disapproval made by the individual. Self esteem has been consistently found to be positively related with life satisfaction, subjective well being, health and happiness (Hong and Gianna-Kopoulous, 1994).

Self-esteem has been studied as a state or as a trait, as primarily cognitive or affective dimension with an emphasis on the extent to which the individual likes himself or herself, and as a series of domain specific evaluations (e.g. academic self esteem and social self-esteem (Rosenberg, 1965).

Millstein et al., (1993) said that throughout adolescence, self-esteem appears to be affected by young people's judgements of their competence in certain valued domains. Domains identified as important include physical attractiveness, acceptance by peers, and to a lesser
extent, academic competence, athletic ability and conduct. Physical attractiveness appears to be particularly important for girls. In addition, perceived support from parents and peers is associated with adolescent self-esteem, with peer support talking on increasing importance during this period.

As regards role of parenting in development of self esteem in teenagers, Millstein et al (1993) reported that parental acceptance, interest, closeness, warmth and respect are positive influences on adolescents’ self-esteem.

Herman (1999) said that self-esteem is a crucial factor in the understanding of subjective well-being. People with high self-esteem are generally expected to be happier than people with low self-esteem. More specifically, positive correlations between measures of self-esteem and well being suggest that high self-esteem accompanies happiness and low self esteem accompanies unhappiness.

According to Watson et al (2002), one may consider how self esteem is related to anxiety and depression. A negative self-concept (i.e low self-esteem) plays a central etiological role in cognitive theories of depression. Moreover, low self-esteem is a common symptom of depression; the Diagnostic and Statistical manual of Mental Disorders (4th ed.; American Psychiatric Association, 1994) for instance, lists “feelings of worthlessness” as one of the symptom criteria for a major depressive episode. Finally, numerous studies have reported a strong negative correlation between self-esteem and self-report measures of depressive symptoms (Joiner et al., 1994).

In contrast, low self-esteem and a negative self-concept play a much more peripheral role in contemporary models of anxiety. This asymmetry leads to the prediction that self-esteem should be more strongly (negatively) related to depression than to anxiety. In support of this prediction, Joiner et al., (1994) found that the Rosenberg’s self-
esteem correlated significantly more strongly with the symptoms of depression than with symptoms of anxiety. On the basis of these findings, it seems reasonable to predict that measures such as the Rosenberg’s self-esteem show evidence of affective specificity, such that they are more strongly correlated with depression than with anxiety (Watson et al, 2002).

**Type A**

Friedman and Rosenman (1978) gave the following definition of Type A behavior, “an action-emotion complex that can be observed in any person who is aggressively involved in a chronic incessant struggle to achieve more and more in less and less time and if required to do so, against the opposing effects of other things or persons”. This definition indicates that what is designated as Type A behavior is a rather broad cognitive, emotional, personal style of functioning. It is characterized by a tendency towards drive, competitiveness, time urgency, impatience, irritability and speed of activity. Type B individuals were seen to be more relaxed, easygoing, readily satisfied and less concerned with achievement.

Glass (1977) viewed Type A behaviour as characteristic style of response to environmental stressors that threaten an individual’s control over the environment in which Type A behavior appears to be an enhanced performance to assert and maintain control over the environment when type A person is challenged.

Why should the Type A behaviour syndrome be an effective coping mechanism for some individuals? proposed that the Type A behaviour is characterised by what they refer to as psychological vigour, which tends to be associated with self-confidence, and global self-assessments of happiness. In other words, Type A individuals often experience their lives as more satisfying and fulfilling. Although Type A’s report higher levels of positive experience than other types, they do
not differ in reported negative experiences. It is therefore possible that the Type A behaviour acts as a source of positive experience rather than to reduce sources of negative experience.

According to Heaven (1996), Type A behaviour is an important coping mechanism. It is now recognized that the TABP is an important predictive variable in coronary heart disease. Consequently, adolescents with elevated levels of Type A behaviour are at risk from coronary heart disease in adulthood. More recently, it has been demonstrated that such teenagers are also at risk for other behavioural problems (e.g. delinquency) and alcohol consumption. According to Heaven (1996) researchers have identified a range of physiological and psychological correlates of the Type A behaviour. For instance, compared to low-Type A individuals, high-Type A teenagers manifest enhanced systolic blood pressure in response to difficult, frustrating, and slow-paced tasks. It has also been found that high-Type A adolescents report significantly higher self-ratings of stress and tension than do low-Type A individuals.

It is quite likely that the Type A can be learnt in the home and that parents who exhibit behaviours and attitudes typically associated with the Type A behaviour often transmit such values to their children. In fact, some studies have found significant associations between this behaviour pattern in fathers and sons, while there is evidence of a link between mothers' levels of verbal hostility and adolescent Type A behaviour (Matthews and Siegel 1982). Other findings demonstrate that parents of Type A children are far more 'encouraging' or 'supportive' of their children's activities than are the parents of non-Type A offspring. As suggested these children are constantly encouraged to 'try just a little harder' and in many cases they have parents who are likely to be more critical of their achievements.

All the above mentioned personality dimensions play a significant role in teenage health.
Many researchers have tried to identify Personality Correlates of Health, Well-Being and Happiness

More than 2000 years ago, Aristotle claimed that ‘It is contemplation alone that yields happiness”. Despite the popularity of paraphrasing Aristotle in current Well-Being/happiness research, his postulate about contemplation has had no impact in the field. Contemplation is almost never mentioned as correlate of happiness or subjective well-being (SWB). Reviews since the days of Wilson (1967) point to such factors as self-esteem, optimism, sociability and Extraversion as the primary sources, or at least correlates, of Health and Well-Being. Moreover, according to many researchers Extraversion is held to be the cardinal trait of happiness and well-being (Lu et al., 1999). However, in a recent meta-analysis DeNeve and Cooper (1998) found that when personality traits were grouped according to the Five Factor Model, emotional stability (i.e. the positive pole of Neuroticism) was the strongest predictor of both life satisfaction, health and happiness, although Extraversion also contributed somewhat in explaining the variance in positive affect. Similarly, studies in which both Extraversion and Emotional Stability are included as independent variables reveal that the effect on satisfaction/Well Being from emotional stability normally outweighs the effect from Extraversion (DeNeve and Cooper, 1998).

According to Hotard et al., (1989), previous research has indicated that there is a relation between Extraversion and subjective well being (SWB), and that the sociability component of Extraversion primarily accounts for this relation. Interactive effects of Extraversion and social relationship variables on subjective well being were hypothesized and found to be significant. In another study these findings using Extraversion scores from Eysenck’s Inventory revealed important interactive relations between Extraversion, Neuroticism, and social relationships in predicting subjective well being and health.
Hotard et al., (1989) further added that, in analyzing Extraversion, most investigators adopt a relatively simple model of the relation of sociability, or Extraversion, to subjective well being. The basic idea, as Wilson (1967) put it, is simply that happiness is consistently related to “successful involvement with people”. He sees social relationships as directly satisfying needs for affection, acceptance, popularity, etc. Hence, extraverted people, who have more such relationships, are happier and healthier. A somewhat more elaborate analysis was suggested by Wilson (1967). He proposed that there is not a simple causal connection in either direction, but rather some sort of dynamic cycle. Those who feel good may be more likely to engage in social activities and engaging in those activities may increase the probability that they will encounter the kinds of experiences productive of positive affect, leading to good health Wilson (1967).

According to Robert et al., (1991) Personality traits and emotions are so intimately tied that it is often difficult to distinguish the items on a mood measure from those on a personality inventory. Yet it has only been in the past decade that systematic links have been made between the structure of emotions and the structure of personality traits. Most of this research has focused on the two dimensions of Neuroticism (N) and Extraversion (E) (Emmons and Diener, 1985) and to a lesser extent on Openness to Experience (O); (Costa and McCrae, 1984). Two other major dimensions of personality viz., Agreeableness (A) and Conscientiousness (C), have not previously been seen as major determinants of well-being, but a role for them was suggested by Freud in his famous dictum about the need for love and work in a satisfying life. Robert et al., (1991) examined the relations of psychological well-being to all five major dimensions of personality.

Many findings have led to the conclusion that happiness, well being and health and the chronic emotional reactions that underlie these dimensions are probably best understood as reflections of
enduring dispositions. Costa and McCrae (1984) proposed a model relating positive and negative affect to the personality dimensions of Neuroticism and Extraversion. Specifically, they hypothesized that Extraversion leads to positive affect, Neuroticism leads to negative affect, and both, indirectly, influence overall happiness. This model has since been widely replicated (Emmons and Diener, 1985; Hepburn and Eysenck, 1989). The explanation for these findings is probably temperamental: extraverts are simply more cheerful and high spirited than introverts; individuals high in Neuroticism are more prone to negative affect than those low in Neuroticism. Watson and Clark (1984) have suggested that the broad dimension one calls Extraversion should be relabeled as positive emotionality.

A recent study by Larsen and Ketalaar (1989) provided some experimental support for the view that Extraversion is positive emotionality. Extraversion was correlated with response to a positive mood induction, whereas Neuroticism was related only to response to a negative mood induction. Individuals high in Extraversion and low in Neuroticism were predisposed to be happy and healthy.

Relations between the third dimension of personality, Openness and affect were qualitatively different. Open individuals were characterized both by a broader and deeper scope of awareness and by a need to enlarge and examine experience; they were imaginative, aesthetically responsive, empathic, exploring, curious, and unconventional (Costa and McCrae, 1984). Humanistic psychologists emphasized these traits as characteristics of fully functioning individuals, and one might expect that open men and women would be higher in psychological well-being. In fact, however, being open is a double-edged sword, because open people experience both the good and the bad more intensely (Costa and McCrae, 1984). Openness scores were positively correlated with both positive and negative affect scores. Openness did not have an affect-biasing influence as
Extraversion and Neuroticism do; instead, it seems to amplify the experience of both kinds of affect, illustrating an experiential influence on well-being.

Robert, et al., (1991) opined that although personality traits may directly affect the tendencies to experience positive or negative emotions, they may also have indirect effects on well-being and health. Certain traits may be instrumental in creating conditions that promote happiness or unhappiness. In particular, the dimensions of Agreeableness and Conscientiousness might be hypothesized to have instrumental effects on well-being and health. Agreeable individuals are warm, generous, and loving; conscientious people are efficient, competent, and hard-working. The interpersonal bonds that Agreeableness fosters and the achievements and the accomplishments that Conscientiousness promotes may contribute to greater quality of life, happiness and higher life satisfaction. This is perhaps what Freud meant when he suggested that Liebe und Arbeit, love and work, were the keys to psychological health and happiness.

The case for expecting a link between Agreeableness and happiness has been made by Costa and McCrae(1984), who cited the importance of interpersonal intimacy and caring for psychological health. They found modest support for the hypothesis: Unhappiness in women and strain and uncertainty in men were negatively related to intimacy motivation.

There are also reasons to expect that the well ordered lives of conscientious men and women may also be more fulfilling. Diener(1984) found that perceived efficacy in personal projects was related to both Conscientiousness and greater well-being.

According to Robert et al., (1991), Neuroticism, Extraversion, and Openness to Experience have been shown to have systematic effects on psychological well-being and health. The remaining dimensions in the five-factor model of personality-Agreeableness and
Conscientiousness may also contribute to increased life satisfaction and happiness. Self-reports and spouse ratings on the NEO Personality Inventory, a measure of the five factors, were correlated with three measures of psychological well being in a sample of 429 adult men and women. Consistent with previous research, Neuroticism was negatively, and Extraversion was positively, related to well-being. Both Agreeableness and Conscientiousness were also significant independent predictors. Thus personality dispositions appear to have temperamental, experiential, and instrumental effects on psychological well-being (Robert et al., 1991).

Robert, et al., (1990) conducted three year longitudinal study of 1,003 urban Black children and explored the relationship between obesity, health locus of control, and self-esteem. Subjects were classified as obese or not obese on 2 occasions approximately 2 year apart. Self-esteem was associated with decreased ponderosity (Weight relative to height) only for subjects who changed from obese to non-obese. Group differences imply that building self-esteem and acknowledging individual differences may facilitate treatment of teenagers' obesity.

Perry and Kelder (1992) discussed the use of social influences (SI) model of prevention to discourage use of alcohol, tobacco and marijuana among teenagers. Research findings supported an SI model with a broad-based approach that focuses on the functions served by the addictive substances, social-environmental factors, personality factors, and behavioural risk factors. Research in the US showed that approaches incorporating a peer-led social influences program effectively delayed tobacco and marijuana use among teenagers; delaying the onset of alcohol use was more challenging. A study by the WHO in 4 countries compared peer-led and teacher-led Social Influences programs of alcohol use prevention. Students in the peer-led groups showed better outcomes than did others at posttest implying
thereby that teenagers more sensitive to social influences are likely to benefit more to avoid health risk behaviours.

Heaven (1996) explored the relationship between health risk taking behaviour and delinquent behaviour (DB) among 296 undergraduates. Females were significantly less involved in delinquent behaviour and registered lower attraction to thrill seeking and higher degrees of self-control and socialization, compared with males. Males who measured high in thrill seeking behaviour and low in self-control reported significantly more property delinquency. Interpersonal delinquency was most influenced by lack of self control. There was a negative correlation between substance abuse and socialization. The reasons most often given for property and substance delinquency were “fun/thrills” while those most often given for interpersonal delinquency involved “anger/revenge”. Risk raking and thrill seeking may be related to substance abuse.

Bender (1995) conducted a study examining the relationship between health locus of control, perceived self efficacy, hardiness and recovery from schizophrenia in teenage and to identify which would be the best predictor of recovery. Although entered fourth in the hierarchical model of the regression analysis, health-related hardiness was the only significant predictor of recovery, explaining approximately 9% of the variance.

Diener (1984) cited studies indicating that the degree of control a person feels over their life covaries with happiness and subjective well being. That is, internals may be become happy because of their ability to bring about positive life circumstances, or alternatively, it could be that happier people tend to seek and find more ways to control events.

Frenkel, et al., (1995) measured locus of control (LOC) in 89 subjects from the National Institute of Mental Health. They concluded that teenagers’ LOC was related to lifetime Mental Health. Sussman et al., (1995), explored the predictive value of problem-
behaviour theory for poor teenage health practices. For this purpose, an index was developed consisting of 7 health risk factors from problem-behaviour theory constructs selected to reflect personality, perceived environment, and behaviour systems, and then administered to students in grade 7 (N=3,674) and again in grade 8 (N=2,776, from the original sample). Factor analysis does not support the constructs; instead, factors reflect domains labeled wellness, subjective distress and problem behaviour. Linear regression indicates that constitutes of wellness and subjective distress and predictive of positive changes in health practices; problem-behaviour indicators related to tobacco use and lower socioeconomic status are predictive of negative changes. Although findings only partially support the relevance of problem-behaviour theory to predicting health risk behaviours, they demonstrate that a teenager’s lack of a sense of wellness may lead to poor health practices in a problem-behaviour related social environment.

A study by Gupta (1996) aimed at studying feeling of inferiority as a source of variation in various areas of adjustment. Nine hundred and sixty eight school going female teenagers, selected randomly, ranging in age from 14 to 18 years, served as subjects. Pati’s Inferiority Questionnaire and Sinha and Singh’s Adjustment Inventory were administered. Pearson’s product-moment correlation and ANOVA were used for analysis of data. Results showed that (i) There exists a significant relationship between inferiority feeling and emotional, social, educational, and general adjustment (ii) The general, emotional and educational adjustment worsened with increasing feeling of inferiority. (iii) The social adjustment was not differentially affected by Low, Mild and Moderate levels of inferiority feeling. The severe level of inferiority feeling significantly worsened social adjustment. (Gupta, 1996).

Ryff (1989) found that extraverts reported better psychological adjustment than introverts. Need for social approval and gender of the
participant were unrelated to self-reports of well-being. Satisfaction with social activities, especially activities involving friends and parents, predicted psychological well-being but the frequency of social activity did not. In another study, internal locus of control, high desire for control, and being female, as well as perceived control over the testing situation, were found to predict better psychological adjustment and health.

Noor (1996) examined the contributions of some demographic (age and education), personality (Extraversion and Neuroticism), and role variables (role occupancy and role quality) as predictors of happiness and symptoms of psychological distress in a sample of employed and non-employed English women (N=145). Using multiple regression analysis, the results showed that personality variables viz. Extraversion and Neuroticism accounted for the largest proportion of explained variance in the well-being measures viz. Distress and Happiness.

According to Heaven (1996) teenagers who believe that they are in control of their lives are better equipped to deal with stress than are those who believe that what happens to them is pre-ordained or just bad luck. Psychological research into the 'locus of control' concept has generated considerable insight into the link between control beliefs on the one hand and attitudes and behaviours on the other (Cauce et al., 1992).

Cauce et al., (1992) examined the link between locus of control and coping and concluded that internal locus of control was significantly related to emotional adjustment and acts as a buffer against stress. For instance, one study of life stress among American high school students (Cauce, et al., 1992) found that those classified as 'internals' were better adjusted in terms of anxiety, as well as general, school, and physical competencies, than were 'externals'. Thus, a sense of control acted as a buffer against stressful experiences by reducing
students' anxiety, thereby helping them to maintain adequate levels of competency.

Similar findings have been reported by Kliwer (1991). She found that internality was related to enhanced coping skills, although she did find some interesting differences between the genders. For example, whereas internality was significantly related to cognitive avoidance as a coping strategy for both genders, girls labeled as internals were also found to be more likely to engage in avoidant action. Kliwer (1991) explained her results in terms of differing socialization experiences between the genders, suggesting that while girls are often encouraged to 'walk away' from the source of stress, boys are encouraged to confront the source of stress (Heaven, 1996).

Furnham and Greaves (1994) found that externals tended to be dissatisfied with their body shape, and have irregular eating patterns, lower self-esteem, and higher depression scores. Internals, on the other hand, tended to exercise for specific body shape reasons. The authors explain the results in the following terms (Furnham and Greaves, 1994). External feel that there is nothing they can personally do to alter their body shape towards the ideal. As a consequence, the resulting feelings of helplessness and hopelessness are likely to be associated with depression and low self-esteem and ill health.

Personality factors believed to be associated with bulimia, a health problem were depressive affect, anxiety, and general emotional distress (Heatherton and Baumeister, 1991). Those manifesting the disorder were shown to score more negatively than normals on measures of depression, while anxiety has been related to feelings of rejection.

Marlatt et al. (1988) reported that some personality and attitudinal factors were related to substance use. These include personal motivations, low self-esteem, impulsivity, sensation-seeking, negative attitudes towards authority figures, high depression, acting out
behaviour (Marlatt et al., 1988), less responsibility and rebelliousness (Brook et al., 1987).

According to Ho (1994) personal motivation are important in explaining why some teenagers continue to use drugs. Teenagers who smoke have clear reasons for so doing. In an Australian study, it was observed that teenagers smoke so as to be socially acceptable (e.g. 'I feel confident'; 'My friends smoke'; 'It allows me to feel part of the crowd'), because it provides them with pleasure (e.g. 'It is enjoyable'; 'It relaxes me'), and because of addiction or habitual needs (e.g. 'I find it difficult to quit').

These motivations for smoking as identified by Ho (1994) have close links with expectancy factors identified by Marlatt and his colleagues (1988). Individuals who have beliefs or expectancies that certain drugs will have specific behavioural or mood effects that make these drugs more desirable to use. Ho (1994) identified two forms of expectancies, namely outcome expectancies and beliefs in self-efficacy. Thus, a teenager might use alcohol because he or she believes that it will help them to relax, or because they believe that it will help them feel more confident.

Braet and Ipema (1997) explored the relationship between personality traits, psychopathology and emotional eating in 105 obese youngsters (aged 5-16 years). Strong correlations were found between psychopathology and emotional eating and between psychopathology and emotional instability. Only a weak correlation was found between emotional eating and emotional instability. In a multiple regression analysis, for emotional eating as a dependent variable, psychopathology was the first and only predictor of eating pathology. Emotional instability (Neuroticism) was the first and best predictor of psychopathology; however when results were studied by gender, this pattern was found only for girls.
Hoefer and Straus (1997) did a research study which included a questionnaire distributed to 750 teenagers aged 12-24 years. Qualitative interviews with teenagers in the sample and a questionnaire with a control group of teenagers showed higher health strains among disadvantaged teenagers. In addition, those teenagers with a below average sense of coherence had significantly more psychosomatic stress symptoms and experienced a greater degree of demoralization than the control group.

According to Headey and Wearing (1989), the dynamic equilibrium model of subjective well being also suggests that personality is critical for subjective well being. This model was developed to explain why individuals give stable reports for their experience of positive events, adverse events, and subjective well being across a period of 2 years. Headey and Wearing (1989) proposed that each person has a normal equilibrium level of subjective well being. This equilibrium level is predicted by personality characteristics, especially Extraversion, Neuroticism, and Openness to Experience. Although subjective well being levels will change when recent life events (either positive or adverse) deviate from their normal pattern, personality characteristics will serve to return subjective well being to its normal equilibrium level.

The work of Ormel and colleagues extended the dynamic equilibrium model to show that personality is more powerful for predicting psychological distress than are external events (Ormel and Schaufeli, 1991).

In addition to Subjective Well Being theorists, personality theorists using either the trait perspective or the psychobiological perspective have also suggested that personality is critical for well being (McCrae and Costa, 1991). These instrumental traits lead people to encounter specific life situations that in turn affect subjective well being.

Frye (1998) wanted to find a precise, efficient method for identifying “Serious Emotional Disturbances” teenagers. Specifically, the
researcher studied the usefulness of the Minnesota Multiphasic Personality Inventory (MMPI) in identifying public school students with Serious Emotional Disturbances. Twelve scales of the MMPI were selected for use in the study, because they were associated with problems in school, or because they related to one of the criteria for Serious Emotional Disturbances. These scales were Hypochondriasis, Depression, Psychopathic Deviate, Paranoia, Schizophrenia, Hypomania, Adolescent-Health Concerns, Adolescent-Depression, Adolescent-Low Self-Esteem, Adolescent –Low Aspirations, Adolescent – School Problems and Immaturity. Scores on the 12 scales were obtained from a sample of 36 students identified as Seriously Emotionally Disturbed, a normative sample of 38 adolescents in general education classes, and a clinical sample of 37 adolescents receiving inpatient treatment. Multivariate Analysis of variance was used to determine significant differences among the 12 scales across the 3 groups. Also, discriminant analysis was performed to determine which scales sorted the students into 3 groups. Results indicated that scores for Psychopathic Deviate, Paranoia, Schizophrenia, and Immaturity, were significantly different between the normative sample and Serious Emotional Disturbances sample as well as between the normative and clinical inpatient sample. Scores were significantly different between the normative and Serious Emotional Disturbances sample for Hypomania. Significant difference were found only between the normative and clinical inpatient samples for Depression, Adolescent-Depression, and Adolescent – Low Self – Esteem. The other scales showed no significant differences among the three groups. Discriminant analysis found a discriminant function that accurately sorted 55.86% of the participants into the their appropriate group. These results suggest that the students with Serious Emotional Disturbances are a subset of a clinical population and that the MMPI could be used to differentiate
students with Serious Emotional Disturbances from a normal population.

Spence (1998) examined teenage perceptions of risk, vulnerability, sensation seeking and locus of control in relation to their involvement in typical adolescent risk behaviours. High school students (N = 178) from an upper middle income suburban community were assessed. Stepwise regression analyses were conducted in order to determine the proportion of variance explained by each independent variable. Sensation seeking scores accounted for 39% of the overall variance in reported risk engagement. Females' perceptions of invulnerability were inversely related to risk-taking, but not for males. The results suggest that improving teenagers' knowledge about the risks associated with drinking, drug use and sex will not in and of itself minimize their involvement in such behaviours. An underlying propensity for engaging in risks may be one of the most critical variables to assess in order to identify teenagers who may be at greatest risk.

Cicognani and Zani (1999) studied the relation among sociodemographic variables, self-esteem, health-locus of control, values, sensation-seeking, optimistic beliefs, and unrealistic optimism in 103 male and female high school students (aged 15 years) and 97 male and female high school students (aged 18 years) in Italy. The results showed that teenagers tend to underestimate personal susceptibility to different risks, that sensation-seeking was a strong determinant of general optimistic beliefs, that age was not related to optimism. Females tended to be more optimistic than males, and that optimism varied according to specific events and risky behaviors.

According to McCrae and Costa (1986) both dispositional and situational variables play a role in the stress and coping process. The personality variable that has received the most attention with respect to stress and coping is Neuroticism. Neuroticism is defined as a...
predisposition to experience negative affect and therefore those who are high in Neuroticism experience more anxiety, depression, hostility, and self-consciousness (McCrae and Costa, 1986).

According to Bolger and Zuckerman's (1995) differential exposure-reactivity model, individual differences in personality have the potential to affect both exposure to stress and subsequent reactivity to the stressful circumstances and consequently affect health.

Hammen (1991) showed that depressed individuals experience higher rates of controllable stressful events than do individuals who are not depressed. In a similar manner, nonclinical research has found that Neuroticism, too, is associated with an increased number of negative life events as well as daily stressors (Bolger and Zuckerman, 1995).

Gunthert et al. (1999) examined the influence of Neuroticism (N) on the occurrence of different types of daily events, primary and secondary appraisals of those events, use of specific coping strategies, and end-of-day negative mood. College students completed questionnaires at the end of every day for 14 consecutive days. When reporting their most stressful events of each day, high-Neuroticism individuals, compared with low-Neuroticism individuals, reported more interpersonal stressors and had more negative primary and secondary appraisals and reacted with more distress in response to increasingly negative primary and secondary appraisals. Compared with low-Neuroticism individuals, high-Neuroticism individuals used less-adaptive coping strategies (e.g., hostile reaction) and reacted with more distress in response to some types of coping strategies. The appraisal findings, in particular, help to explain the chronic negative affectivity associated with Neuroticism.

Ruchkin et al. (1999) conducted the study in which the aim was to test for possible interrelations between hopelessness, loneliness, self-esteem, and personality in samples of delinquent Russian
teenagers, (n=187) and controls (n=103). The results revealed that self esteem, personality characteristics, loneliness and hopelessness were higher among delinquent teenagers than controls.

According to Brief et al., (1993) stable personality dimensions, such as the Big Five have been demonstrated to related to subjective well-being. Neuroticism, revealed a significant negative relation, and Extraversion and Openness to experience a positive relation to global well-being (Diener et al., 1995). Also with regard to subjective health, fears about disease (i.e., health-related Neuroticism) were among the strongest negative predictors of well being.

Carvajal et al., (2000) investigated a broad range of social influence-related and global determinants of smoking. Multivariable logistic regression analyses was used to examine the statistical significance and strength of the factors. Those lower in self-esteem and higher in social assertiveness appeared to be most at risk for the onset of smoking, whereas those low in optimism appeared to be the most at risk for the escalation of smoking. Attitudes, friends’ norms, parents’ norms, perceived behavioural control, and perceived prevalence were consistent predictors of all smoking status outcomes.

Nigg (2000) reported that sedentary life styles have been identified as a serious health problem and a major public health concern for young people. The psychological and physiological benefits of exercise are well established. For this purpose, 819 Canadian teenager (mean age= 14.99, SD=1.22; 51.28% male) were approached for a three-year longitudinal follow-up data collection. The main conclusions of this study were that Self efficacy and the behavoiural processes of change contributed to the prediction of adolescent exercise adoption and maintenance.

Markey and Ericksen et al., (2001) examined the predictive value of parental monitoring and preadolescents’ personality traits in determining preadolescents’ participation in health-promoting and
health-compromising behaviours. 130 preadolescents (aged 10-12 years) and their mothers completed measures assessing preadolescents’ personality traits, perceptions of parental monitoring, and preadolescents’ participation in healthy and risky behaviours. Findings revealed that preadolescents’ reports of parental monitoring predict their tendency to engage in healthy and risky behaviors. Mothers’ and preadolescents’ reports of youths’ personality traits explained unique variance in preadolescents’ participation in risky behaviors, but not in their health-promoting behaviors. Familial influences could best explain preadolescents’ adoption of healthy behaviors. However, as children reached adolescence, individual differences in personality appeared to be more important predictors of risky behaviors.

In yet another study, Vitterso and Nilsen (2002) did two things: to analyze and explore the conceptual structure of Subjective Well Being (SWB) and to compare the effect sizes on Neuroticism and Extraversion as predictors of Subjective Well Being. Results supported the notion of an overall subjective well-being construct sustained by the three nested dimensions of life satisfaction, positive affect and negative affect. Neuroticism explained eight times as much of the Subjective Well Being variance as did Extraversion. Hence both Extraversion and Neuroticism should be included as independent variables in regression models to predict Subjective Well Being, happiness and life satisfaction.

Aatlo, et al., (2002) examined mental health risk factors as predictors of mental distress in early adulthood. 709 Finnish teenagers (aged 15-19 years) were studied in 1990 and again in 1995. Trait anxiety, defense styles, life events, self-esteem and somatic symptoms were evaluated as predictors of high scores in the General Health Questionnaire in adulthood. High trait anxiety and somatic symptom scores among teenaged female and high immature defense style
scores among males predicted mental distress. Males with low trait anxiety in teenage had less distress. The results implied that trait anxiety was an important predictor of mental distress and mental health.

According to Diener et al., (1999) one of the most consistent findings in the study of personality and emotions is that Extraversion is moderately correlated with pleasant affect. People who are gregarious, active, and outgoing tend to experience more pleasant emotions than those who are quiet, inactive, and introverted (Costa and McCrae, 1980; Watson and Clark, 1997). As early as 1937, G.B. Watson (cited in Wilson, 1967) found that social relations and feelings of sociability correlated with avowals of happiness; and Wilson (1967) identified social activity as an important predictor of happiness in an early review of the literature. In 1969, Bradburn suggested that pleasant affect could be separated from unpleasant affect and that social activity was more strongly related to the former than to the latter. Replicating this finding, Costa and McCrae; (1980) found that Extraversion was correlated with pleasant emotions and Neuroticism was correlated with unpleasant emotions, which together made up overall happiness.

In the years since the Extraversion-pleasant-affect relation was identified, personality researchers have begun to investigate its causes. Diener et al.,(1984) undertook a number of studies investigating whether or not person-situation fit could account for extraverts' greater happiness. These researchers hypothesized that extraverts may be happier than introverts because of their greater social activity or greater enjoyment of social activity. Similarly, Argyle and Lu (1990) examined whether extraverts' social skills could lead to greater pleasant affect. In each of these models, extraverts' greater pleasant affect is an indirect outcome of their greater sociability. These indirect-effects models have yielded limited success: Extraverts do benefit from greater social participation and higher levels of social skills; but these factors cannot completely account for extraverts' greater pleasant affect.
According to Bandura (1997), perceived self-efficacy refers to beliefs in one's capabilities to produce given attainment. It is well conceivable that individuals with a low sense of self-efficacy are at risk for developing depression. A recent longitudinal study by Bandura (1997) tested this idea in a teenaged population. More specifically, the connection between self-efficacy and current depression and depression at one and two years follow-up was examined. Results indicated that low levels of self-efficacy were associated with high levels of concurrent and subsequent depression.

Personality is also related to different coping styles. According to McCrae and Costa (1986) generally, Neuroticism (N), which is characterized by a tendency to experience negative affect, hostility, self-consciousness, and impulsiveness, has shown the strongest association with coping (McCrae, 1992). Individuals high on Neuroticism have been found to be less likely to employ problem-focused coping strategies. However, they are more prone to engage in emotion-focused means of coping, such as wishful thinking, avoidance-escapism, self-blame, withdrawal, mental and behavioural disengagement, venting of emotion, and passivity. They are also less likely to cope by means of positive appraisal and seeking social support, thereby being more vulnerable to mental health problems (McCrae, 1992).

According to DeNeve and Coper (1998), individuals high on Extraversion (E) tend to experience positive emotions and are described as warm, sociable, assertive, and fun loving. Studies have shown that high Extraversion is associated with problem-focused coping, social support seeking, and positive reappraisal. Extraverts are also less likely to engage in emotion-focused coping (McCrae and Costa, 1986).

High scores on Conscientiousness (C) were associated with being hardworking, reliable, purpose-driven, and trustworthy. Thus, as might be expected high Conscientious individuals are more inclined
towards problem-focused coping strategies, such as planning and suppression of competing activities, and also tend to avoid emotion-focused coping (Watson and Hubbard, 1996).

High scores on Agreeableness (A) reflect a courteous, trusting, harmony-seeking, and helpful personality. Thus, it is not surprising to find that high A individuals prefer seeking social support in times of stress. Also, they are less likely to utilize emotional ways of coping and confrontational coping (O’Brien and DeLongis, 1996).

Openness (O) is associated with being imaginative, creative, receptive to ideas and feelings, and flexible. Data on coping styles among high O scorers are mixed, possibly because the coping scales available so far are less sensitive to tapping coping strategies related to being open. Open individuals have been found to use more emotional coping and humor (McCrae and Costa, 1986), although they can be hypothesized to be effective copers since their receptiveness and originality should sensitize them to more diverse coping strategies. Supporting this prediction, some studies have demonstrated a tendency for open individuals to engage in positive reappraisal (O’Brien and DeLongis, 1996).

According to O’Brien and DeLongis (1996), different coping styles relate differentially with health status. Coping styles have been examined in relation to personality variables such as hardness, optimism, Type A, and locus of control (Carver et al., 1989; Parkes, 1994). Carver et al. (1989) demonstrated that active coping and planning was positively associated with optimism, self-esteem, hardness, and Type A, whereas active coping was negatively correlated with trait anxiety. In contrast, denial and behavioral disengagement were found to be positively associated with trait anxiety, but negatively related to optimism, self-esteem, and hardness.

Similar patterns were found by Endler and Parker (1990). Trait anxiety was negatively related to task-oriented coping but positively
related to emotion-focused coping and avoidance. Other studies such as those by Billings and Moos (1984), suggest that individuals endowed with "healthier" personality traits, tend to cope by dealing with problems directly and/or viewing problems positively. By contrast, those scoring lower on these personality characteristics and higher on traits such as trait anxiety and Neuroticism have a tendency to cope by emotional methods such as wishful thinking and self-blame, thereby becoming more vulnerable to health problems.

Bishop et al., (2001) investigated the relationship between coping styles and personality among 243 male police officers from the Singapore Police Force. Examination of the rotated canonical variables indicated that problem solving, composed of Active Coping, Suppression of Competing Activities, Planning, Restraint Coping and Instrumental Social Support, was positively associated with Conscientiousness. Avoidance Coping, which included Behavioral Disengagement, Mental Disengagement, Denial, and Focusing on and Venting of Emotion, was positively related to Neuroticism but negatively related to Conscientiousness. Finally, Positive Reappraisal, which included Emotional Social Support, Turning To Religion, Positive Reinterpretation and Growth, and Acceptance, was positively associated with Extraversion, Agreeableness, and Openness (Bishop, et al., 2001).

Mullis and Chapman (2000) reported the three-factor structure of the A-COPE was consistent with earlier research and lends support to the usefulness of categorizing coping strategies into emotion- and problem-focused strategies. Also in accord with previous research, the teenagers with higher self-esteem used more problem-focused coping strategies, and the teenagers with lower self-esteem used more emotion-focused coping strategies. The present findings add to the growing literature supporting the importance of positive self-worth and
self esteem among teenagers who must cope effectively with stress in their lives and thus avoid ill-health.

Marchesi et al., (2001) examined risk factors for eating disorders in Italian teenagers. 2,991 high school students (aged 16-18 years) residing in Italy completed questionnaires concerning bulimia, eating attitudes, self-reported personality disorders, and demographic characteristics. Results showed 12.6% of females subjects and 2.2% of male subjects were diagnosed for eating disorders. Female gender was associated with increased risk. For females, borderline, antisocial obsessive-compulsive and histrionic personality traits were associated with eating disorders. For males, antisocial and avoidant personality traits were risk factors for eating disorders (Marchesi et al., 2001).

According to Robins et al., (2001), although no previous studies have focused on the relation between self-esteem and the Big Five, several studies have reported Big Five correlates of self-esteem. Most of the studies used college students samples and found that self-esteem had a strong positive correlation with Emotional Stability and moderate positive correlations with Agreeableness and Openness.

According to Diener and Lucas (2002), individuals differences in both personality and Subjective Well Being emerge early in life, are stable over time, and have a moderate to strong genetic component. These findings have led some to conclude that Subjective Well Being is primarily determined by our inborn predispositions. Others have argued that the importance of inborn traits may depend on the types of questions we ask about SWB. For example, Lucas et al., (2002) argued that by looking at Subjective Well Being within individual over time, researchers will find that life events and life changes have important implications for well-being beyond the effects of personality. Yet, regardless of the origins of individual differences, personality and Subjective Well Being researchers must develop precise theories that
can explain why certain individuals are chronically happier and more satisfied with their lives.

Other researchers have argued that average differences in well-being are due to differences in emotional reactivity. Based on Gray’s (1970, 1991) theory of personality, Rusting and Larsen (1997) argued that extraverts are more reactive to pleasant emotional stimuli than are introverts, and neurotic individuals are more reactive to unpleasant emotional stimuli than are stable individuals. Although there has been some support for individual differences in reactivity in laboratory studies (Rusting and Larsen 1997), evidence of real-world reactivity assessed in experience-sampling studies has been mixed (Gable et al., 2000, Lucas et al., 2002), and the small differences in reactivity that have been found do not account for all of the covariance between personality and Subjective Well Being.

Kircaldy et al., (1999) conducted a number of studies and have examined the combined role of the Type A behaviour pattern, locus of control and anxiety. One approach has typologized individuals into four personality profiles based on a combination of Type A and Type B behaviour and perceived locus of control (Kircaldy, et al., 1999). It is suggested that Type A externals display the highest levels of anxiety and the lowest levels of well-being while Type B internals show the lowest anxiety levels and the highest well-being (Kirkcaldy et al., 1994).

According to Birks and Roger (2000), although above mentioned findings are valuable for understanding how broader personality profiles are related to health they fail to focus on the strivings, needs and fears which govern the cognitive and affective processes involved. Self-related strivings may be an important factor underlying the experience of control, anxiety and threat.

Parkes (1986) reported that personality and coping are exclusively related to the outcomes of stress and each is of importance in the prediction of adjustment or stress outcomes. In line with this
finding, Terry (1994) showed that both dispositional and situational factors influence coping responses. In a study by Fleischman (1984), coping responses were influenced more by the nature of stressful encounters than by personality variables. These studies indicate that many factors are involved in an individual’s attempts to cope with stressful life events and remain healthy.

Pastorelli et al., (2002) studied the relation of self-efficacy, prosocial behavior, popularity, and externalizing and internalizing behaviors on school achievement in 443 male and 416 female 6th – 8th grade students in Italy. The results indicated that school failure was associated with psychosocial adjustment problems and that academic self-efficacy beliefs, social rejection and delinquent behaviour affect school performance. The results also showed that underachievement in 6th grade was associated with compromised adjustment pattern and risk for externalizing and internalizes problems at the end of a school year.

According to Watson et al., (2002) the fact that self-esteem is substantially related to both Neuroticism and Extraversion, one would expect it also to be significantly correlated with both Negative and Positive Affectivity. This prediction consistently has been confirmed. Numerous studies, have shown that the self-esteem was moderately to strongly correlated with measures of both Positive and Negative Affect.

Because Neuroticism reflects broad individual differences in subjective distress and dissatisfaction (Watson et al., 1994), it is not surprising that this trait was strongly (negatively) correlated with global measures of self-esteem, with coefficients typically exceeding – .50.

Watson et al., (2002) found that self-esteem was strongly negatively correlated with Neuroticism (r = -.69) and Negative Affectivity (r = -.53) and was moderately to strongly correlated with Extraversion (r = .46) and Positive Affectivity (r = .62). With regard to the remaining Big Five traits, Self Esteem was very weakly related to both Openness (r = .10) and Agreeableness (r= .12) and more moderately correlated
with Conscientiousness (r = .43). In second study, global self-esteem had significantly negative higher correlations with the two depression scales. The level of specificity in these relations again is quite impressive: Whereas the Self Esteem shared 41-45% of its variance with the depression symptoms, it showed only 6-9% overlapping variance with anxiety.

According to Raikkonen et al. (1999) aspects of personality relate to health outcomes as diverse as asthma, ulcers, heart disease, hypertension and minor illness reporting. Additionally, aspects of personality predict numerous health behaviours known to impact health status. A key issue concerns whether it is the general personality trait or a unique aspect of the trait that predicts health. Although some investigations examine a more general trait like Neuroticism, others focus on specific traits such as Optimism (Scheier and Carver, 1993). The current investigation examined which level of specificity for measuring personality provides a better predictor of self-reported health outcomes.

Watson, et al. (2002) studied the relation between dimensions of personality and positive and negative affect. The results revealed that positive and negative affect schedule was positively correlated with Extraversion, Openness, Agreeableness, Conscientiousness and negatively correlated with Neuroticism, Depression, and Anxiety.

Ben (2003), investigated the associations of personal and parental factors with subjective well-being (SWB) in teenagers on the basis of 2 studies. The first included 97 university students (aged 18-30 years) and 185 (15-17 years) olds who completed questionnaires measuring perceived mastery, dispositional optimism, and affect used as a measure of subjective well being. Data showed mastery and optimism to be negatively associated with negative affect (NA) and positively associated with positive affect (PA). Demographic variables did not relate to positive affect and negative affect except for gender,
with female teenagers showing higher levels of negative affect than males. The second study included 121 (15-19 years) old and their parents who completed questionnaires measuring mastery, optimism, subjective well being indicators and assessments by the teenagers of their relationship with their parents. The associations of the teenagers' mastery and optimism with subjective well being measures were positive and were similar to those found in the first study. Positive correlations were found between teenagers' and parents' mastery and optimism. However, teenagers' mastery and optimism were related to positive relationships with parents.

According to Trzesniewski, et al., (2003) global self-esteem is one of the most frequently studied variables in psychology. Research has linked high self-esteem to many positive outcomes, including occupational success, healthy social relationship, subjective well-being, positive perceptions by peers, academic achievement, persistence in the face of failure and improved coping and self-regulation skills. Conversely, low self-esteem has been linked to a number of problematic outcomes, including depressive symptoms, health problems and antisocial behavior.

The traditional role of self-esteem in studies of personality and health has been that of a buffer against adverse events (Pearlin and Schooler, 1978). This static concept of self-esteem, referring to something we have, is related to many personality traits such as anxiety or locus of control. Other dispositions, like those involved in the Type A pattern, presuppose a more dynamic concept of self-esteem which refers to something we strive for (Cantro, 1990 and Dweck, 1996).
STRESS DURING TEENAGE

What Hall called a period of storm and stress, Mohan (2002) defined as a period of transition, turbulence, trance and tension unmatched for its energy and impact on the rest of life.

The teenage years are a time of transition and change. It is now well accepted that teenagers face a multitude of developmental challenges incorporating social, cognitive, and physical changes. Social change refers, for example, to events such as the transition to high school. For some, this is a critical period when the security and familiarity of primary school is exchanged for new and uncertain friendships in high school. Cognitive change refers to the fact that teenagers have acquired the ability to think abstractly. This is an important developmental change, for adolescents are now in a position to contemplate the unknown as well as the possible long-term effects of events. They are now able to consider ‘what if’ and for some this can be stressful. Physical changes include the many hormonal and biological changes taking place in the body. The teenager must now adapt to a changing body and for some this change is occurring faster (or slower) than it is for others. Thus, for late or early maturers a normative transition is taking on non-normative dimensions with added stress (Heaven, 1996). Some changes reflect a combination of events. The gradual awakening of interest in members of the opposite sex reflects, biological and social changes.

Adolescence has traditionally been viewed as a time of ‘storm and stress’. In this regard, psychoanalytic writers have tended to hold sway, viewing adolescence as a period of emotional turmoil and as a period of ‘disarray’. Thus, for instance, Anna Freud stressed the importance of Oedipal feelings within the teenager, linking these to anxiety. Notable characteristics of the teenage years, according to the
psychological point of view, are a host of drives, instincts, and motives that can become problematic and stressful during the adolescent years when, for example, a developing sexuality needs to be incorporated into the overall structure of personality or one’s personal identity (Heaven, 1996).

Papalia and Olds (1989) reported generation gap between parents and teenagers to be another source of stress. According to Erikson (1968) a major challenge that all adolescents must confront is the development of a personal identity or a sense of psychological wellbeing. Teenagers live in a ‘no-man’s-land’, caught between childhood and adulthood.

Heaven (1996) said that as we move to the next millennium, young people seem to be increasingly affected by stress. Earlier it was assumed that only adults get affected by stress, it is common knowledge now that teenagers and even children face stress which has the potential to negatively affect their psychological adjustment and health.

Some common stressors teenagers face are being bullied at school and conflict at home. Many recent studies in India and abroad have confirmed the prevalence of stress and stress related physical and mental health problems among teenagers. The figures provided by Bhagwanprakash (2002) are highly disturbing, when one finds 200% rise in adolescent suicide; 20% suffering emotional turmoil; 18% girls getting depressed and a growing number experiencing sexual exploitation and experimentation leading to AIDS, unwanted pregnancies and promiscuity. Social deviance and defiance; revolt and revulsion; accidents and accusations; caricaturing and creativity and above all stage of being different is what one calls teenage (Mohan, 2002).
Stress and Teenage Health

McNamara (2000) studied 'stress in young people' and opined that there is growing concern in most countries today about increasing levels of stress among young people. Suicides, substance abuse, depression, anxiety, and eating disorders have all been linked to stress. Young people are experiencing more social and psychological problems than ever before. These trends indicated an increase in the pressures facing young people, together with a general decline in coping skills and an absence of social support. Such patterns have emerged world-wide and represent a challenge to policy makers, service providers, and families alike.

In India recent investigations in the area of adolescent problems have concluded that approximately 80% of teenagers do not experience marked or persistent stress and turmoil. One implication of an 80% prevalence rate of normality among adolescents is that about 20% of adolescents are disturbed. Indeed, the majority of existing investigations examining prevalence of psychiatric disturbances among children and adolescents are in agreement in finding that approximately 20% are disturbed. Epidemiological studies done in Indian context have given a wide range of prevalence rate from 2% to 30% for the psychological problems among adolescents (Kapur, 1992; Sinha and Kapur, 2001; Bhola and Kapur, 2000).

However, recently some theorists (Petersen, 1988; Susman et al., 1992) have questioned the universality of the view that ‘adolescence is a period of stress and storm’. There is a possibility that teenagers may successfully cope with challenges of adjusting to changing body image, volatile emotion and mood swings.

Nature of Stress

According to Heaven (1996) our understanding of the nature of stress has undergone considerable change over many years. For instance, in the mid-1900’s stress was regarded simply as a set of
bodily defences or physiological responses to undesirable stimuli, while by the 1970s it was seen as a ‘state of the body’ (Lazarus and Folkman, 1984). Recently, writers have proposed more formal definitions of stress incorporating aspects of the stressor and the individual. For example, Brooks-Gunn (1991) viewed stress as an individual response to events which is said to occur when an individual is confronted with an event that is perceived as threatening, requires a novel response, is seen as important (i.e. needs to be responded to), and for which an individual does not have an appropriate coping response available. Selye (1956) defined stress as the non-specific response of the body to any demand. Lazarus and Folkman (1984) defined stress thus: Psychological stress is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being.

According to International Encyclopedia of Psychology (1996) stress is an adaptative reaction to circumstances that are perceived as threatening. It motivates people and can enhance performance. Learning to cope with adversity is an important aspect of normal psychological development, but exposure to chronic stress can have severe negative consequences if effective coping mechanism are not learned. The stress of contemporary life could impair immunologic functioning and increase susceptibility to disease.

Stress is a psychobiological process that is characterized by alterations in psychological, behavioural and physiological response systems that are directed towards adaptation. It is initiated by stressors, events or thoughts that threaten, harm or challenge the organism or that exceed one’s available coping resources. While stress can facilitate adaptation to a range of situations, prolonged or extreme episodes of stress may have negative effects on physical and mental health. Factors affecting appraisal of stressors or coping can moderate these
negative effects and promote successful adaptation and are the focus of many treatment strategies aimed at preventing or alleviating symptoms caused by stress (Dougall et al., 1998).

Stewart (1999) defined adolescence stress as the feelings of apprehension or fear of anxiety, nervousness or possibly panic or anger elicited by anxiety producing interpersonal demands, exacerbated by irrational, self defeating and sometimes self-fulfilling cognitions.

Larsen (2000) opined that stress is the subjective feeling that is produced by events that are perceived as overwhelming and beyond one’s control. Events that typically elicit stress are called stressors. There are individual differences in response to stress. Stress really lies in the transaction between the person and the characteristics of the environment. Personality processes may moderate this transaction.

**Types of Stressors**

There are to type of stressors viz. life event stressors and chronic stressors.

**Stressful Life Events,** According to Encyclopedia of Stress (2000), a life event stress is a comprehensive list of external events and situations (stressors) that are hypothesized to place demands that tend to exceed the capacity of the average person to adapt. The difficulty in adaptation leads to physical and psychological changes or dysfunction, creating risk for psychological disorder or physical disease.

Solanki and Ganguli (1987) stated that life stress refers to a state of imbalance with an organism that (i) is elicited by an actual or perceived disparity between environmental demands and the organism’s capacity to cope with these demands, and (ii) is manifested through variety of psychological, emotional and behavioural response.

Newcomb *et al.* (1986) interviewed over 1,000 American teenagers and asked respondents to rank the most desirable and least desirable life events, to understand sources of stress results are shown in Table A.
Table A
Most and least desired life events for teenagers

<table>
<thead>
<tr>
<th>Most desired</th>
<th>Least desired</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Started driving</td>
<td>Got or gave venereal disease</td>
</tr>
<tr>
<td>2. Got own stereo TV</td>
<td>Death in the family</td>
</tr>
<tr>
<td>3. Making own money</td>
<td>Serious accident or illness</td>
</tr>
<tr>
<td>4. Fell in love</td>
<td>Family accident or illness</td>
</tr>
<tr>
<td>5. Started dating regularly</td>
<td>Had a gay experience</td>
</tr>
<tr>
<td>6. Met a teacher I liked a lot</td>
<td>Trouble with the law</td>
</tr>
<tr>
<td>7. Holidayed without parents</td>
<td>Parents abused alcohol</td>
</tr>
<tr>
<td>8. Joined a club or group</td>
<td>Parents argued or fought</td>
</tr>
<tr>
<td>9. Decided about university or college</td>
<td>Thought about suicide</td>
</tr>
<tr>
<td>10. Accepted Religion</td>
<td>Family, money problems</td>
</tr>
</tbody>
</table>

Very few gender differences were observed between the rankings of males and females.

Rice et al. (1993) said that there are three types of stressors: normative stressors, non-normative stressors, and daily hassles. **Normative Stressors** are those events that all adolescents must confront e.g., physical changes, transition to high school etc. **Non-Normative Stressors** refer to those events that can occur at any time. Included in this category are parental divorce, death of a loved one, a bad grade at school and so forth. Research evidence indicates that those teenagers who are able to vividly recall parental conflict or family tensions are more at risk from health and behavioural problems such as depression, impulsive, aggressive and sexual behaviours, and relationship problems (Hauser and Bowlds, 1990).

Other non-normative stressors that have important implications for adolescent behaviour and mental health are parenting styles and parental psychopathology (Heaven, 1994). For example, it has been
well documented that adolescents who are raised in authoritative homes are higher on competence and adjustment and lower on problem behaviours. By contrast, those teenagers residing in neglectful homes risk mental anguish and problem behaviours.

**Second Category of Stressors are Hassles (also called Chronic Stress)**

*Hassles* are irritants-things that annoy or bother you, they can make one upset or angry whereas *Uplifts* are events that make one feel good, joyful, glad or satisfied. Some hassles and uplifts occur on a fairly regular basis and others are relatively rare. Some have only a slight effect, while others have a strong effect. The role of daily stress or hassles as a causal factor in illness has motivated widespread use of measures of stress based on life events and daily hassles.

Daily hassles are day-to-day events that, cumulatively, result in stress for the individual. It has been argued that normative and non-normative stressors multiply the number of daily hassles that teenagers have to contend with (Rice et al. 1993). In other words, a major stressor (such as parental divorce) has a number of associated consequences (feeling of guilt in the adolescent; adaptation to new family. Family stressors are also example of non-normative stressors e.g., conflict between parents and children.

The repetitive daily hassles of life are better predictors of illness than major life events. Losing a wallet, a price rise in the weekly food bill, and the breaking of a window may ultimately negatively affect health more than deaths and divorces (Dohrenwend and Shrout, 1985).

Teenagers and their parents are usually agreed as to the sources of conflict within the home. Smetana and her colleagues (1991) found that conflict was most likely to occur over chores (18% of the time), inter-personal relationships (16%), the regulation of teenagers’ activities (12%), personality characteristics (11%), homework (9%), bedtime and curfew (9%), regulating social relations (8%), and appearances (8%).
Models of Stress

There are few areas of contemporary psychology that receive more attention than stress (Hobfoll, 1988). This literature reflects researchers' belief that stress is a major factor affecting people's lives, is intimately tied with mental health, and is very possibly linked with many problems of physical health. The interest in stress has also caught interest of lay public.

The Cannon-Selye tradition: Response Models of Stress

Cannon (1932) was probably the first modern researcher to apply the concept of stress to humans. Cannon was principally concerned with the effect of cold, lack of oxygen, and other environmental stressors on organisms. He concluded that although initial or low level stressors could be withstood, prolonged or severe stressors lead to a breakdown of biological systems.

Cannon's emphasis on stress as responses was carried on by Selye (1950; 1951-1956). Selye depicted stress as an orchestrated defence operated by physiological systems designed to protect the body from environmental challenges to bodily process. He called this the General Adaptation Syndrome. Specially, he felt that there was a common reaction to outside stressors following the sequence of alerting response, resistance response, and exhaustion.

Stimulus Models of Stress

A less well-articulated view of stress may be identified in terms of depicting stress from the nature of the stimulus, as opposed to the response. Elliot and Eisdorfer (1982), for instance, have focussed on stressors, or that which is likely to cause stress, as the object of interest. They outlined four kinds of stressors: (a) acute, time-limited stressors, such as a visit to the dentist, a wasp entering the car while one is driving, or a woman awaiting breast biopsy; (b) stressor sequences, such as divorce, bereavement, or job loss; (c) chronic, intermittent stressors, such as examinations for students, meetings with
business associates one dislikes, or a regimen of visits to a physician for painful treatments; and (d) chronic stressors, such as debilitating illness, prolonged martial discord, or exposure to occupation-related dangers.

**Event-Perception Models of Stress**

Another perspective that was influential to stress researchers is a viewpoint that focuses both on the category of stressor events and the individual differences in the appraisal of those events.

The research of Spielberger (1988) is illustrative of this viewpoint. Spielberger suggested that certain events are stressful if they are thought to be threats to the physical self or the phenomenological self. He called these physical threats as ego-threats. Although individuals with different personalities responded somewhat uniformly to physical threats, people’s responses to ego-threats were related to personality traits. In particular, Spielberger noted that people with high trait anxiety tended to react with state elevations in anxiety to ego-threat, whereas those who were low in trait anxiety tended to be comparatively impervious to ego-threats. In this way, it is neither the stimulus nor the appraisal that is important, but rather their particular interaction.

**Homeostatic and Transactional Models of Stress**

Probably the most commonly adopted model of stress employed by stress investigators today is a homeostatic model of stress presented in detail by McGrath (1970), but based in large part on the work of Lazarus (1966). McGrath defined stress as a “substantial imbalance between environmental demands and the response capability of the focal organism”. More recently, Lazarus and Folkman (1984) have defined stress as “a particular relationship between the person as taxing or exceeding his or her resources and endangering his or her well-being”.

Implied in these definitions is that stress is not the product of imbalance between objective demands and response capacity, but of
the perception of these factors. Second, the consequence of failure to cope must be perceived as important to the individual.

**The Conservation of Resources: A New Stress Model**
*(Hobfall, 1988)*

Hobfall presented a new stress model that he believed more closely reflected current understanding of the ubiquitous stress phenomena and perhaps bridges the gap between environmental and cognitive viewpoints. He argued that the proposed model is clearly testable, comprehensively explains behaviour during stressful circumstances, and is more parsimonious than the balance or transactional model, while still encompassing the relative importance and complexity of cogitations. The model's basic tenet is that people strive to retain, protect, and build resources and that what is threatening to them is the potential or actual loss of these valued resources. He termed this model as the *model of conservation of resources* *(Hobfoll, 1988).*

The view that individuals actively seek to create a world that will provide them pleasure and success is a long-standing one in psychology, but one that has been relatively ignored in stress theory. Freud (1913) introduced the *pleasure principle,* the notion that humans instinctually seek that which is pleasurable. Maslow (1986) also proposed that people seek physical resources, then social resources, then psychological resources, in a hierarchical manner. Pearlin et al., (1981) have similarly proposed “that the protection and enhancement of self ... are fundamental goals after which people strive”. Social learning theory proposed that people actively engage their environment in order to increase the chances of obtaining positive reinforcement *(Bandura, 1977).* There are two basic ways to achieve these goals. First, people act to enhance the likelihood of situational (i.e., here and now) reinforcement. Success is more likely, however, if individuals seek to create and maintain personal characteristics (e.g., mastery of self-
esteem) and social circumstances (e.g., tenure or intimacy) that will increase the likelihood of receipt of reinforcement and to avoid the loss of such characteristics and circumstances. The model of conservation of resources rests on this second strategy.

The definition of stress is derived directly from the models and the above mentioned basic tenet: *Psychological stress* is defined as a reaction to the environment in which there is (a) the threat of a net loss of resources, (b) the net loss of resources, or (c) a lack of resources gain following the investment of resources. Both perceived and actual loss or lack of gain are envisaged as sufficient for producing stress, said Hobfall (1988). Resources, are the single unit necessary for understanding stress. Resources are defined as those objects, personal characteristics, conditions, or energies that are valued by the individual or that serve as a means for attainment of these objects, personal characteristics, conditions, or energies. Examples of resources include mastery (Pearlin and Schooler, 1978), self-esteem (Rosenberg, 1965), learned resourcefulness (Rosenbaum and Smira, 1986), socioeconomic status (Worden and Sobel, 1978), and employment (Parry, 1986). Any threat of loss of resources causes stress.

**Appraisal of Resources**

Until this point, emphasis has been placed on objective loss and shared social standards of what constitutes loss. The model also proposes an important role, however, for appraisal (Lazarus & Folkman, 1984). Many stress theories have suggested that appraisal is the key to stress resistance.

**Stress-Health Relationship**

Emotional well-being has been the subject of a fivefold increase in research over the past decade (Myers and Diener, 1995). Summarizing several decades of research (Lazarus and Folkman, 1984) documented abundant evidence that supports the theory that too much emotional stress impairs individuals and group functioning.

85
Alternatively, increasing positive emotions—beyond the absence of emotional distress—enhances performance and productivity (Lazarus and Folkman, 1984).

Psychobiologic research in the latter half of the 20th century has produced dramatic changes in the conceptualisation and study of disease etiology. Beginning with early observations on the temporal linkage between major life events and occurrences of illness, investigators from a diversity of fields have produced strong evidence for a robust and arguably causal relationship between emotional stressors and susceptibility to human disease. These pioneering studies have introduced new and fundamentally different categories of pathogenic “agents” into the lexicon of medicine and human biology. Taking their place alongside traditional agents of disease—microbiologic organisms, physical toxins, and genetic anomalies—psychosocial factors have become increasingly recognized as “predisposing” agents in the events leading to the development of physical and mental disorders (Haggerts et al., 1994).

Moore and Schultz (1983) said that loneliness is a major stress among teenagers. One hundred adolescents were given measures of loneliness, loneliness attributions, coping styles, and personal characteristics. Results revealed that loneliness was positively related to state and trait anxiety, an external locus of control, depression, self-consciousness, and social anxiety and negatively related to self-reported attractiveness, likeability, happiness, and life satisfaction.

Compas et al. (1986) examined relationship among major life events, perceived social support, and psychological disorders in a sample of older adolescents. Negative life events and satisfaction with social support were significantly and independently related to a range of psychological symptoms. Further, the relationship between negative events and disorder was moderated by gender.
Hammen and associates (Hammen et al., 1989) reported findings with college students and unipolar depressives that indicated that stressful events were more likely to be associated with symptoms of depression when they fall into domain of interpersonal relations.

Emmons (1991) opined that life events and personality posit domains of vulnerability within which individuals are most likely to be affected by negative life events. A variation of this model was tested in a study of the separate as well as interactive effects of daily life events and personal strivings on psychological and physical well-being. Results revealed that power strivings were negatively correlated with well-being. Affiliation strivings were correlated with positive affect. No significant between-subject interactions occurred between strivings and events. However, within-subject analyses revealed several significant effects. Achievement-oriented individuals tended to be affected by good achievement events. Similarly the moods of affiliation and intimacy-oriented individuals were affected by interpersonal events.

Chen (1993) conducted a cross-cultural investigation on determinants of headache and reviewed literature from 1937 to 1987 to examine age, gender and stress factors; headache characteristics; and modalities of pain control in adult headache with inference for their significance in childhood headache. Four major conclusions were reached: (1) The prevalence of migraine increases from approximately 7% in children to 11.5% in adults; (2) more than 60% of patients report severe headache in a trend that is consistent across nations, with females reporting greater severity than males; (3) physical and psychological stressors appear to be the major precipitating factors of headache; (4) while medication is the most commonly used from of treatment, rest and relaxation appear to be important coping mechanisms for headache.

Ge-Xiaojia et al. (1994) examined a mediational model of the relationship between the stressful life events experienced by parents
and adolescent's depressed mood. Findings from the present study indicated that stressful life events experienced by parents were first related to parents' depressed mood which disrupts skillful parenting practices. The disrupted parenting practices in turn place adolescents at increased risk for developing depressive symptoms.

Conger et al., (1995) conducted a study of parental stress and adolescent adjustment. Experiences of negative life events during the recent past were used to generate a measure of acute stress. In addition, multiple indicators based on reports from various informants were used to estimate latent constructs for parental depression, discipline practices, and adolescent adjustment. The findings showed that parental stress was related to adjustment through stress-related parental depression that is, in turn, correlated with disrupted discipline practices. Poor discipline appears to provide the direct link with developmental outcomes.

Snyder et al., (1996) examined the effect of stress on humoral immune response (IgG) in 89 healthy female university students who were immunized with a novel antigen, keyhole limpet hemocyanin (KLH). More stressful events (of any type) appeared to raise IgG levels at 8 weeks. Psychological distress scores correlated negatively and psychological well-being scores correlated positively with each IgG level. Subjects with a recent infection or a local reaction to immunization had higher IgG levels. Recent stress and psychological status may influence immune response.

Hartos and Power (1997) examined relations among mothers' awareness of their early adolescents' stressors, mother/adolescent communication, and adolescent problem behaviours. 161 ninth graders and their mothers completed the Inventory of High School student's Recent life experiences, the Parent/Adolescent communication Scale, and Anxious/Depressed and Aggressive subscales on the Child behaviour Cheklist. The results showed that adolescents reported
experiencing more stress for 8 content areas than mothers reported for their adolescents. Mother/adolescent communication was related inversely and significantly to adolescent problem behaviours. Mother's awareness of adolescent stress was related significantly and positively to adolescent’s reports of mother/adolescent communication and significantly and negatively to adolescents reports of their anxious/depressed and aggressive behaviours. The findings indicate that mothers were only minimally aware of their adolescent’s stressors and that adolescents whose mothers were more aware of their adolescents’ stressors and who communicated more with their adolescents reported better adjustment.

Larry and Robert (1997) examined the relations of subjective well-being with the cognitive processing of affectively valenced life events. They reported that both more intense and more enduring reactions to positive life events than negative ones were associated with higher well-being.

Abu (1998) examined the role of life events in precipitating suicidal behaviour in adolescents in Jordan. The study investigated suicidal attempts of individuals between the ages of 12-20 years. The results revealed that conflict with their families, scholastic failure and breaks with close friends were the most frequent events which precipitated suicidal behaviour in adolescents.

Chapman (1998) did a study which extends the literature on somatic complaints in adolescents by examining the social context of neighbourhood in relationship to known to somatic complaints. The findings included strong paths of influence between neighbourhood quality and previously known links to somatic complaints, such as stressful life events, family environment, and psychological distress.

Hagquist (1998) described the link between economic stress and perceived health among Swedish adolescents. Worry about family finances was strongly linked to the adolescents’ perceived health. The
occurrence of perceived poor health was much greater among those 
who were frequently or constantly worried about their family’s finances 
than among those who seldom or never experienced such worry. The 
relationship between economic stresses and perceived health was also 
stronger than the relationships between other types of stresses and 
perceived health. In addition, those adolescents who, during the last 
month, were often unable to afford various recreational activities, 
exhibited a greater degree of perceived poor health than others.

De-Goede et al. (1999) examined the effects of stressors in both 
the vocational and relationship career of youngsters in the formation of 
their identity; the effects of identity formation on adolescent mental 
health; the influence of career stressors on mental health, directly or via 
identity and differences in these effects on boys and girls. Career 
stressors, and stressors in the relationship domain, appear to have 
significant long term effects on adolescent mental health. Vocational 
and relationship identity formation were also significant predictors for 
adolescent mental health.

Holmes and Frentz (1999) reported that stressful events are 
those factors that have a potential for causing an imbalance between 
environmental demands and individuals’ resources for dealing with 
them. Stressful events in children have been shown to relate to 
behaviour problems, particular when events can substantially alter a 
child’s environment, such as parental divorce or separation in addition 
to the family environment.

Printz et al (1999) did a study to uncover the factors that buffer 
the impact of stressful negative experiences on adolescent adjustment, 
Overall, the findings replicated previous investigations that have 
demonstrated direct relationships among stressful life events, support, 
problem solving, and adolescent adjustment.
Hoffmann et al. (2000) reported that life events stress leads to increased usage of drugs moderated by social support in the form of family attachment.

Aguilar (2001) compared the adaptational fate of Early-Onset/Persistent (EOP) and Adolescence Onset (AO) antisocial behaviour groups during young adulthood. The robust finding that the Early-Onset/Persistent was associated with high levels of maladaptation across all major arenas was replicated, and this group's high levels of antisocial behaviour persisted into young adulthood. Although previous theoretical work has asserted that the Adolescence Onset pattern is normative and time-limited, results indicated that Adolescence Onset youth showed signs of compromised adaptation (higher life stress, more drug use, more psychological problems) compared with the Never antisocial (NA) control group, and that a notable portion of this group continued to show elevated levels of antisocial behaviours in young adulthood.

Guthrie et al. (2001) examined the relationship between cigarette use, age of smoking initiation and daily life hassles including academic/school, social/peer, family/economic and personal safety. The sample was divided into adolescents who had ever smoked in their lifetime and adolescents who had never smoked before. Results showed that less than 50% of the teenagers had ever smoked in their lifetime and adolescents who had never smoked before. Results showed that less than 50% of the teenagers had ever smoked cigarettes, and of those who had ever smoked, the average age of initiation was 12.5 years. Further more, girls who had ever smoked, in contrast to girls who had never smoked, had a significantly greater number of daily life hassles in general and within the school/academic and family/economic domains in particular. Age of smoking initiation was negatively related to number of hassles, indicating that girls who started to smoke at a younger age reported more hassles.

Steinhausen and Matzke (2001) examined the contribution of general risk factors for mental disorders as well as compensatory,
vulnerability and protective factors in a general population sample of preadolescent and adolescent students. Data was collected by questionnaire in a representative sample of 1110 (10-17 year old) subjects in a school based quota sample in Zurich. General risk factors for both sexes which emerged were increased self-awareness, avoidance behaviour, perceived rejection by the parents, competitive behaviour among classmates, and controlling behaviour by the teachers. Performance stress served as a risk factor in girls and a vulnerability factor in boys. Active coping and peer acceptance were protective factors for internalising disorders and peer acceptance was also a compensatory factor for externalising disorders among teenagers.

Picardi and Damiano (2001) said that a causal influence of emotional stress, especially of stressful life events, on the course of various skin diseases has long been postulated. Clinical wisdom and experience, as well as many anecdotal observations and uncontrolled case series, support this motion. According to the available evidence on the role of stressful life events in triggering of exacerbating skin diseases, the role of stressful events in vitiligo, acne and dermatitis was either controversial or insufficiently explored. The role of stressful events in psoriasis, alopecia areata, atopic dermatitis and urticaria was apparently clearer.

Sehgal (2000) explored the relationship of Anger Expression styles with mood disorders, anxiety and depression in addition to optimism, Coronary prone behaviour pattern and degree of pain experienced were also studied as correlates of anger expression styles. Sample included 100 backache patients (25 to 35 years). Spielberger's Anger Expression Inventory (Spielberger 1984) and Beck Depression Inventory were administered to the subjects. As anticipated, suppression of anger resulted in preponderance of physical and mental
symptoms, whereas anger expression was associated with joy, health and optimism.

Misra and Chandna (2001) investigated differences between male and female adolescence in respect of their self-concept and adjustment. Sample was selected from a public school. There were 40 girls and 40 boys of tenth class. The age group was 15-16 years. Sample belonged to high middle class. Results revealed significant gender, physical, social, educational self concept and social and home adjustment.

Sehgal and Sehgal (2001) opined that the role of psychological factors in health and disease began with the work of Dunbar and Alexander in early 1930’s. Since then, a plethora of evidence highlighting the association of stress, hostility, irritability and anger with various chronic diseases has accumulated. Among the personality dimensions Type A and Locus of control are the ones which have shown the most consistent relationship with health.

Several earlier studies like those of Mohan and Sehgal (2000) pointed to a close relationship between internal/external locus of control and healthy behaviour. The primary purpose of this study was to document the relationship of Health locus of control with health status and negative emotions of anger and stress. The assumption was that externality would be associated with poorer health status and disease prone behaviour i.e. anger and greater stress experiences.

The sample comprised of 200 male adolescents in the age range of 15 to 18 years. They were selected randomly from various secondary schools. Results revealed that among the adolescents, Internal Health Locus of control was positively related with health status and negatively with anger and stress. External health locus of control showed the opposite trend i.e. it was positively associated with anger and daily hassles and negatively with health status.
Overall, in the control of health, the adoption of an internal or external locus of control is likely to determine the motivation of an individual in indulging activities promoting health. Anger proneness and daily hassles experienced contribute negatively to one’s health and failure to manage them may result in poorer health. In an earlier study also Sehgal (2000) found that both among Indian boys and girls external locus of control was a negative predictor of health status and physical fitness. One may conclude therefore that since even among adolescents, negative role played by certain behaviour dimensions viz. Locus of control, stress and anger in health is clear, greater attention needs to be paid in training children in healthy behaviour patterns at an early age to prevent adult onset of chronic diseases.

According to Sinha et al. (2001) emotional problems in teenaged boys as a separate group have not been dealt with due concern in India. They made an attempt to identify prevalence and impact of emotional disturbance in Indian adolescent boys. A sample of 685 school going boys of 9th and 10th grades were screened at two levels with the help of General Health Questionnaire and Youth Self-Report respectively. Results revealed a prevalence rate of 5.69% for emotional disturbance among adolescent boys. These emotionally disturbed adolescent boys had significant adjustment problems in the area of school and peers.

Torsheim and Wold (2001) investigated the relationship between shared psychosocial school environment and subjective health complaints. The results revealed that school class differences in psychosocial environment accounted for 40% of the variance in health complaints.

Waters and Salmon (2001) examined the impact of common illnesses and health concerns on health status and well-being of adolescents. Results revealed that health status worsened has health concerns increased.
Byrne and Mazanov (2002) reported that adolescent stress has been retrospectively associated with various measures of smoking behaviour in school aged samples. They sought to extend this into a prospective investigation in order to examine the possibly formative influence of stress on the onset of smoking in adolescents. Sociodemographic profiles, current smoking behaviours, sources and intensity of stress (via a 31-item questionnaire), and psychological distress (via the General Health Questionnaire) were assessed. A 12-month follow up study related sources and degree of adolescent stress measured at study commencement with the onset of smoking behaviour 12 months later in 2,625 adolescents attending Australian secondary schools. Adolescents stress was related to smoking onset in adolescent males. In adolescent girls, however prospective associations were stronger and more broadly represented across the various domains of adolescent stress, suggesting that stress may exert a formative influence on smoking onset for girls.

McEwen and Dhabhar (2002) reported a strong association between stress effects and immune system.

Mohan and Sehgal (2002) conducted a study to assess stress, coping and health cognitions among adolescents. They opined that adolescence is the most turbulent challenging and stressful period. Teenage years have been recognized as crucial for later emotional physical health. From the point of view of health, adolescence is an important period because during this phase, a number of health compromising behaviour may emerged (e.g., smoking, drinking, taking drugs and practising unsafe sex). The present study focussed on measuring health and illness cognitions among adolescents. In addition their perception of stressors and coping and their relationship with personality and health status was explored. For this, 200 adolescence (15-18 years) half from each gender comprise the sample. They were administered HLOC Scale, Daily Hassles inventory and Rating Scale to
assess health status. Results revealed internality to be negatively related with health status and negatively with stress experienced. There was a clear difference in the health practices of internal and external adolescents. The findings revealed that daily hassles may impact adolescent health negatively whereas, internality may promote health related behaviour.

Heth and Somer (2002) said that "Controllability awareness" describes the extent to which an individual’s responses to life situations reflect attention to distinctions between controllable and uncontrollable aspects of potential outcomes. Results indicated that individuals with a greater tendency to respond based on an awareness of the controllability of potential outcomes perceive their lives as less stressful, report themselves to be in better, health and think in ways that enable them to manage environmental demands more effectively.

Khan and Ghilzai (2002) said that the impact of terrorism creates a state of mind where fear, anxiety and stress dominate people’s thinking and behaviour. To examine the mental health status and coping strategies, 60 adolescents (13-17 years) and 60 adults (21-55 years) with equal number of terrorist affected and controls, were randomly selected from Srinagar (Kashmir). As compared to controls. Significantly poor mental health status was found in terrorist affected group and the impact of terrorism was greater on adolescent subjects than on adults. Moreover, problem-focussed strategies in contrast to emotion-focussed ones were employed more by adults than adolescents.

Rabin (2002) discussed the possibility that stress may be associated with the pathogenesis of autoimmune disease. Multiple Sclerosis (MS) was used as an example of an autoimmune disease whose clinical activity was modulated by stress. Several studies were reviewed that indicated an association between experiencing high levels of life stress and the clinical course of Multiple Sclerosis.
Sirohi (2002) reported that conflicts must be resolved to preserve Mental Health. Sirohi (2002) examined the impact of humour, economic status and sex on the resolution of conflicts. The findings suggested a clear role of humour in conflict resolution.

Sleilagh et al. (2002) reported that children of parents who suffer from bipolar disorder are largely ignored by psychiatric services despite the fact that they constitute a population at very high risk for major depression and bipolar disorder in adulthood and a wide variety of disorders in childhood and adolescence. Major depression and bipolar disorders are chronic, recurrent disorders that seriously impair psychosocial functioning across the life-span. Evidence suggests that in this population bipolar disorder is preceded by externalising disorders in childhood in many cases, and by depression in some cases. While heredity provides the vulnerability for the development of these characteristics, being raised by parents who model inappropriate coping skills, create a stressful family environment, and provide inadequate support and structure, contribute to consolidating these characteristics.

According to Vitaliano et al. (2002) there is extensive empirical support for the hypothesis that chronic stress is associated with cardiovascular disease.

Wills et al. (2002) reported that studies of several types of populations have noted that stress is linked to cigarette smoking. Measures of negative affect and negative life events have been linked to maintenance and relapse for smoking among adults. A linkage with stress has also been found for alcohol use and opiate use. The observed relationship of stress and smoking has been a basis for theoretical models that include constructs of affect regulation and coping functions. This concept is consistent with laboratory evidence and with the self-reports of smokers, who have commonly reported that smoking provides coping functions.
The authors conducted a comparative test of the hypothesis that (a) stress is an etiological factor for smoking. Participants were a sample of 1,364 adolescents, initially surveyed at mean age 12.4 years and followed at three yearly intervals. Measures of negative affect, negative life events, and cigarette smoking were obtained at all four assessments. Latent growth modelling showed negative affect was related to increase in smoking over time.

Wills et al. (2002) reported that there was a positive correlation between stress and smoking.

Dunkley and Zuroff (2003) in a study of university students (64 men and 99 women) examined both dispositional and situational influences of self-critical perfectionism on stress and coping, which explain its association with high negative affect and low positive affect. Participants completed questionnaires at the end of the day for 7 consecutive days. Structural equation modelling indicated that the relation between self critical perfectionism and daily affect could be explained by several maladaptive tendencies associated with self critical perfectionism (hassles, avoidant coping, low perceived social support). Multilevel modelling indicated that self critical perfectionists were emotionally reactive to stressors that imply possible failure, loss of control, and criticism from others. Those who desisted anti-social behaviour in teenagers were compared to persisters in anti-social behaviour it was found that family stress and care were important and persisters reported more anxiety/depression and mental health problem.

Kim et al. (2003) investigated the hypothesized reciprocal influences between stressful life events and adolescent maladjustment using data from a 6-year, prospective longitudinal study. Stressful life experiences, internalising symptoms, and externalising behaviours were assessed for a sample of adolescents (215 males, 236 females) living in the rural Midwest. From 7th to 12th grades, autoregressive analyses showed that stressful life events and these two forms of maladjustment
were reciprocally interrelated over time, although the association between life stress and adolescent depressed and anxious mood is fairly well established (Menaghan 1999).

Shek (2003) examined the association between perceived economic stress and adolescent adjustment. Higher levels of economic stress related to lower levels of existential well-being, life satisfaction, self esteem and mastery as well as higher levels of general psychiatric morbidity and substance abuse in adolescents. Relative to current economic stress perceived by adolescents, future economic worry perceived by adolescence was more strongly related to the psychological well being of these adolescents.

Mohan and Sehgal (2003) in a study on teenagers reported the following sources of stress, ways of coping, values of life, ideal in life and the ways to illness preventive measures. 200 teenagers (100 boys and 100 girls) reported the following perceptions of boys and girls-a bit similar and slightly different. Results are revealed in the following tables.

**Sources of Stress**

<table>
<thead>
<tr>
<th>BOYS</th>
<th>GIRLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAREER</td>
<td>UNCERTAIN FUTURE</td>
</tr>
<tr>
<td>EXAMINATION</td>
<td>EXAMINATION</td>
</tr>
<tr>
<td>STUDY/TEACHERS/BOOKS</td>
<td>PARENTAL EXPECTATION</td>
</tr>
<tr>
<td>HEALTH PROBLEM</td>
<td>PARENTAL</td>
</tr>
<tr>
<td>QUARRELS WITH PARENTS</td>
<td>QUARRELS/ARGUMENTS</td>
</tr>
<tr>
<td>GIRLFRIENDS</td>
<td>PUBLIC OPINION</td>
</tr>
<tr>
<td>REPUTATION</td>
<td>LOSING LOVED ONES</td>
</tr>
<tr>
<td>LACK OF RECOGNITION</td>
<td>SOCIAL NORMS</td>
</tr>
<tr>
<td>FAMILY PROBLEMS</td>
<td>BOYFRIENDS/SELFISH</td>
</tr>
<tr>
<td>LONELINESS</td>
<td>APPEARANCE/BEAUTY</td>
</tr>
<tr>
<td>DEPRESSION IN FAMILY</td>
<td>PARTIAL TEACHERS</td>
</tr>
<tr>
<td>SCOLDING OF FATHER</td>
<td></td>
</tr>
<tr>
<td>TUITION</td>
<td></td>
</tr>
<tr>
<td>BAD COMPANY</td>
<td></td>
</tr>
</tbody>
</table>
Ways of Coping

b) BOYS
- LISTENING TO MUSIC
- PLAYING/EXERCISE
- MEDITATING/SITTING QUIETLY
- TALKING TO PARENTS/FRIENDS
- UNDERSTANDING/PROBLEM SOLVING
- KEEPING CALM/ANGER CONTROL (THINK POSITIVELY)
- ADMITTING MISTAKE
- PUNCHING THE WALL
- SLEEPING
- TRAVELLING/GOING OUT
- WATCHING WWF
- TAKING ALCOHOL

GIRLS
- SHARING WITH MOTHER
- LISTENING TO OTHER MUSIC
- MEDITATION/PRAYING
- CRYING
- HANDLING THE PROBLEM
- DIRECTLY
- EXERCISE/WATCHING T.V.
- WRITING DIARY
- SLEEPING
- PLAYING WITH PETS
- EATING
- SHOPPING
- DRINKING WATER

Values and Priorities of Life

c) BOYS
- STAYING HAPPY
- HARD WORK
- QUALIFICATION/STUDY
- EDUCATION/FUTURE
- CAREER
- RESPECT OF ELDERS
- OBEDIENCE
- PARENTS’ DREAM
- WISDOM/TRUST
- FAITHFULNESS
- SELF RESPECT
- TO BE GOOD
- ENJOYMENT

GIRLS
- PARENTS
- OBEDIENCE/HONESTY
- TRUTH/FIDELITY
- SELF CONTROL / ESTEEM/
- RESPECT / MORALITY
- GOD
- MY TALENT
- RESPECTING TEACHERS
- PATRIOTISM
- AMBITION
- MONEY
- ENJOYMENT
Ideal In Life

d) BOYS                   GIRLS

STUDY                              FATHER
FAMILY                             MOTHER
CAREER                             UNCLE/GRANDFATHER
PARENTS/SISTER                     FRIEND
GOOD CITIZEN                       SELF RELIANCE /
BE A GREAT BUSINESSMAN            CONTENTMENT

Ways to Prevent Illness

e) BOYS                   GIRLS

Proper Diet/Milk                   Proper Diet
Active/Exercise/Work out /Yoga     Exercise/Fitness/Waking
Appearance                         Right Medication
Health Club                        Taking precaution
Antibiotic (if sick)               Not having Paunch
Sleeping                           

101
COPING STRATEGIES AND TEENAGE HEALTH

Coping is a continuous cognitive and behavioural process of overcoming stress and stressful consequences of external forces (Mohan, 2003). Teenage is the time to identify sources of stress and subsequent strategies to manage them. According to Cower (1994) the ubiquitous term stress is used to describe many different situations that pose threats to wellness: real and perceived; mild and intense; specific and diffuse; anticipable and non-anticipable; acute and chronic. Although much evidence suggests that stress predisposes adverse physical and psychological sequelae, this broad generalization is differentially valid for different stressors (e.g., daily hassles vs. life event stress). The more severe, uncontrollable, broad-ranging and enduring the stress, the greater is its risk - enhancing quality and the more likely is it to undermine wellness. Even so, for any given type and level of intensity of stress (objectively defined), the thought – provoking reality remains that people vary greatly in the extent to which they perceive the situation as stressful and the range of adaptations that follow.

The concept of childhood resilience, that is, coping and adapting well in the face of major life stress (Cower 1994), is an important issue. Resilient youngsters, described as “healthy children in unhealthy environments” and as those who “overcome the odds”, offer intriguing clues about pathways to wellness, even under the most dire conditions. That such resilient outcomes occur with no special programming or intervention, suggests that early wellness-enhancing processes such as sound attachment and self-efficacy, empathy, social problem-solving skills, and sense of security competence acquisition help to forge protective attributes which in turn, act both to minimize the perceived stressfulness of life situations and to promote effective coping when stress occurs (Fonagy et al, 1994).
According to Heaven (1996) teenagers face many challenging experiences and they need to acquire effective coping mechanisms. Just how young people cope with major life events and transitions play an important determining part in their emotional adjustment.

One may define coping in a variety of ways: According to Compas et al, (2001) a central feature of human development involves coping with psychosocial stress. Beginning in infancy, individuals are confronted with a stream of potentially threatening and challenging situations that require action and adaptation. The modest to moderate correlations typically found between stressful life events and disorder during childhood and adolescence suggest that individual differences factors related to coping may moderate the stress illness relation. This perspective on coping is best reflected by Lazarus and Folkman’s (1984) definition, “Coping is defined as constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person”. They further pointed out that managing stress includes accepting, tolerating, avoiding, minimizing the stressor as well as the more traditional view of coping as mastery over the environment. Coping is not limited to successful efforts but includes all purposeful attempts to manage stress regardless of their effectiveness.

Functions of Coping

According to Lazarus and Folkman (1984) Coping efforts have been delineated into those intended to act on the stressor (problem-focussed coping) and those intended to regulate emotional stress associated with or resulting from the stressor (emotion-focussed coping). Efforts to act on the stressor include strategies for problem solving or altering the stressful relation between the individual and the environment. Alternatively, adjustment or adaptation can be facilitated by emotional regulation achieved through avoiding the stressor, cognitively reframing the stressor, or selectively attending to positive
aspects of the self or situation. Problem and emotion-focused coping can be carried out through either cognitive or behavioural channels.

Child and Adolescent Coping

According to Compas et al, (2001) applying these general notions of coping to the actions of children and adolescents requires some alterations and additions. First, the nature of the infant or young child’s dependence on adults for survival emphasizes the need to include the child’s social context in understanding his or her coping resources, styles, and efforts. Thus, adaptive coping cannot be characterized by a description of the individual’s skills or resources alone but instead lies in the relation between the child and the environment. Whereas this relational definition of coping may apply throughout life, it should be especially important early in the development. Second, the child’s coping efforts will be constrained by his or her psychological and biological preparedness to respond to stress. For example, temperament is frequently cited as playing a central role in influencing the child’s coping responses. The child’s temperament may define a range of responsivity to stress and influence the style that characterizes the child’s coping. Children differ in their sensitivity to the environment, with some showing signs of arousal and distress to a much wider array of stimuli than others. More responsive children may need to cope with a greater number of situations than less responsive youngsters.

Diener and Welborn (1994) defined coping as “how people relate their behaviour, emotion, and orientation under conditions of psychological stress”. Coping directed at behaviour, relation includes information seeking and problem solving; emotion regulation includes maintaining an optimistic outlook.

Eisenberg and colleagues defined coping as a subset of the category of self-regulation (Eisenberg et. al., 1997). That is, they acknowledged that individuals are involved in the regulation of their behaviour and emotions on an ongoing basis, and coping refers
specifically to self-regulation when one is faced with stress (Eisenberg et al, 1997). They distinguished among three aspects of self-regulation: attempts to directly regulate emotion (emotion-focused coping, henceforth labeled emotion regulation), attempts to regulate problem situation (e.g., problem-focused coping, including thinking about how to do so), and attempts to regulate emotionally driven behaviour e.g., behaviour regulation, (Eisenberg et al, 1997). Eisenberg, et al, (1997) argued that though coping and emotional regulation are processes that typically involve effort; coping is not always conscious and intentional. Therefore, similar to the perspective of Skinner and colleagues, in this framework coping includes both volitional and somatic responses to stress.

Compas et al, (2001) viewed coping as one aspect of a broader set of processes that are enacted in response to stress. They further defined coping as conscious volitional efforts to regulate emotion, cognition, behaviour, physiology, and the environment in response to stressful events or circumstances. These regulatory processes both draw on and are constrained by the psychological, cognitive, social and emotional development of the individual. An individual’s developmental level both contributes to the resources that are available for coping and limits the types of coping responses the individual can enact. Coping is a subset of broader self-regulatory processes, referring to regulatory efforts that are volitionally and intentionally enacted specifically in response to stress (Compas et al, 2001).

Dimensions of Coping

According to Compas et al, (2001), the most widely used dimensions of coping are problem-versus emotion-focused coping, primary versus secondary control coping, and engagement (approach) versus disengagement (avoidance) coping.

The problem-and emotion-focused dimension reflects the function of coping responses to either act on the source of stress in the
environment or palliate negative emotions that arise from a stressful encounter or event (Lazarus and Folkman, 1984). Lazarus and Folkman (1984) defined problem-focused coping as including responses such as seeking information, generating possible solutions to a problem, and taking actions to change the circumstances that are creating stress. They argued that emotion-focused coping involves such responses as expressing one's emotions, seeking solace and support from others, and trying to avoid the source of stress. This dimension has been widely used in research on coping in childhood and adolescence (Compas et al, 2001).

However, criticism of this dimension is also widespread, because it is overly broad and places many disparate types of coping into these two general categories. For example, emotion-focused coping has included such varied strategies as relaxation, seeking emotional support from others, writing about one's deepest emotions, wishing that the problem would go away, emotional suppression, and self-criticism. Furthermore, a single coping strategy may be directed toward both problem-and emotion-focused goals simultaneously (Compas et al, 1996). For example, walking away from a conflict with a peer may serve the emotion-focused goal of calming oneself down and the problem-focused goal of taking time to generate alternative solutions to the conflict.

The distinction between engagement and disengagement coping has also received considerable attention in research with children, adolescents, and adults. Engagement coping includes responses that are oriented either toward the source of stress or toward one's emotions or thoughts (e.g., problem solving or seeking social support); disengagement coping refers to responses that are oriented away from the stressor or one's emotions or thoughts (e.g., avoidance, withdrawal or denial). Although the dimension of engagement - disengagement coping is related to the dimension of approach and avoidance, the
engagement-disengagement distinction is broader, in that avoidance represents only one way in which an individual can disengage. Response such as cognitive distraction also involve disengagement but are not purely avoidant, because they include redirecting attention toward an alternative target and reflect awareness and acknowledgement of the stressor (Compas et al, 2001).

**Coping and Health are Intimately Related**

According to Skinner et al., (2003) coping researchers agree that the study of coping is fundamental to an understanding of how stress affects people, for better and for worse. Although it has proven difficult to document unequivocally, coping researchers argue that how people deal with stress can reduce or amplify the effects of adverse life events and conditions, not just on emotional distress and short-term functioning, but also long-term, on the development of physical and mental health or disorder, researchers maintain that coping matters.

Compas et al. (1993) reviewed research concerned with stress and coping during adolescence, using depression as a key example of a consequence of stress and coping. Genetic, acute, and chronic stress subtypes were discussed in addition to individual responses to stress, and gender differences in regard to psychopathology. It was proposed that exposure to and appraisals of interpersonal stress combine with aspects of biological development and the use of maladaptive coping strategies to account for the emergence of significant gender differences in depression and other forms of psychopathology during adolescence.

Herman and Petersen (1996) explored changes in 458 sixth grade students coping and social resources over a one year period. Subjects were from a rural working class community divided into 4 groups based on indices of depression. The results indicated that asymptomatic subjects reported higher levels of optimism, mastery, active coping, and more positive relationships with parents and peers.
than did symptomatic subjects. These same characteristics distinguished the resilient subjects from the vulnerable subjects, suggesting potential stress-buffering effects. One year later, the subjects who were low on both depressive symptoms and negative life events continued to report more individual and contextual resources than the subjects in the other groups.

Kavsek and Seiffge (1996) investigated the process of coping with daily problems during adolescence. Coping was conceptualized as a trait-like construct and, as such, is seen as being stable over time. This assumption was tested by constructing coping factors for two different age groups of adolescents (11 to 16 year olds vs. 17 to 19 years old). According to the results, the younger subjects use approach and avoidance coping factors. However, the older adolescents, the approach dimension is differentiated into behavioral and cognitive components, whereas the avoidance dimension remains the same. The results also indicated that the girls in both age groups have significantly higher values in approach-oriented coping than boys.

Lee and Larson (1996) explored which coping strategies for dealing with examination stress contributed to lower rates of emotional and physical problems among Korean adolescents. Results showed that problem-solving and information-seeking coping were found to be related to reduction in depression; however, emotional-discharge coping was related to an increase in physical symptoms. Coping with exam stress was found to be related to adjustment and independent of the level of additional life event stress.

Satija et al. (1997) studied the relationship between coping responses in 50 depressed and 50 non-depressed patients. The results revealed that the depressives were using significantly fewer problem solving and more of avoidance coping behaviour as compared to their non-depressed counterparts.
Jose et.al. (1998) compared self-reported stress, coping, and depression between 270 Russian and 270 American early adolescents of 10 to 14 years of age. The results revealed that Russian and American adolescents reported equal levels of major life stress, but Russian adolescents reported greater levels of everyday life stress. Russian adolescents reported that they were less likely to use externalizing coping and more likely to use social support and problem-solving coping compared with American adolescents. Russian adolescents also reported that they were more depressed. Path model analyses showed that Russian and American adolescents coped with stress in similar ways. A buffering effect for social support on depression was found for both national groups.

Gomez et al. (1999), examined the association of neuroticism, avoidant coping style and maladjustment. Two hundred and sixteen, 12 and 13 year old adolescents completed questionnaires covering neuroticism, avoidance coping and maladjustment. The maladjustment levels were also rated by their parents. Results for a sub-sample (N=101), who indicated some degree of maladjustment showed that neuroticism predicted avoidant coping and parent rated maladjustment positively. Avoidant coping showed a positive non-significant trend in the prediction of parent-rated maladjustment, and it also moderated, by exacerbating, the effect of neuroticism or maladjustment. Results did not indicate mediation by avoidance coping on the relation between neuroticism and parent-rated maladjustment.

Bowker et al. (2000) reported that coping strategy use within the peer domain was examined to determine whether adolescents with varying levels of peer experience cope differently with their daily hassles. Two distinct behavioral profiles were examined: aggressive behavior and socially withdrawn behavior. It was hypothesized that these two behavioral profiles would predict differential coping strategy use in the peer domain. It was also expected that perceived control
would mediate the association between peer experience and coping. Results showed that the more aggressive subjects perceived more control over their peer hassles. More withdrawn subjects perceived more limited control over their peer hassles, and they used fewer negative strategies and fewer problem-focused strategies.

Byrne (2000) investigated the relationships between anxiety, fear, self-esteem and coping strategies in a sample of 224 post primary students (aged 12-18 yrs; Ss in school years 7, 9 and 12) in Australia. In particular, it sought to determine whether there were any significant changes between years 7 and 12 and, if so, whether these changes were gender specific. The results indicated that the girls had consistently low levels of self-esteem. The boys showed a significant decrease in both anxiety and fear by year 12. For the coping strategies, a three-factor solution accounted for 64.2% of the variance. Finally, the findings suggested, that, by year 12, boys and girls were using different coping strategies, with boys more successfully reducing both fear and anxiety was examined.

Grant et al. (2000) examined individual (coping strategies), family (parent-child relationships), and community-based (religions involvement) variables as potential protective factors for 224 low-income urban 6th-8th-grade African-American adolescents (mean age 12.32 years). Each variable was examined (through surveys) as a moderator and analysis were conducted to determine whether the association between stress and psychological symptoms was attenuated for youth endorsing positive coping strategies, strong parent-child relationships and religious involvement. Results indicated that positive relationships with father figure buffered the effects of stress on externalizing symptoms for boys and girls; religious involvement was protective for girls but not for boys. The sole coping strategy to demonstrate a protective effect was avoidant coping, which attenuated the relation between stress and externalizing symptoms for boys.
Supplementary analysis focusing on specific subsets of stressful experiences indicated that avoidant coping and social support-seeking coping accentuated the relation between daily hassles and internalizing symptoms for girls.

Griffith et al. (2000) investigated developmental and cross-situational differences in strategies adolescents use to cope with family, school and peer stressors. The relation between adolescents’ use of coping strategies and two indices of adjustment (self perceptions of their adjustment as a result of coping with the specific stressor and state anxiety).

Harvey and Byrd (2000) examined the relationship between 95 university students (mean age 19.6 yrs) perceptions of their familial attachment and the manner in which their families cope with life's difficulties. It was hypothesized that individuals with high levels of secure attachment would perceive their families as using more active coping strategies (e.g., mobilizing the family to deal with a problem and making efforts to acquire social support). The results supported this hypothesis. Further, individuals with high levels of anxious/ambivalent attachment perceived their families as using a passive appraisal coping strategy. It is suggested that this is because of a desire to avoid confrontation for fear of disturbing family accord.

Kumperminc and Allen (2001) examined a model of problematic adolescent behavior that expands current theories of social skill deficits in delinquent behavior to consider both social skills and orientation toward the use of adaptive skills is an ethnically and socio-economically diverse sample of 113 male and female adolescents (aged 14-18 years). Adolescent social orientation, as reflected in perceived problem solving effectiveness, identification with adult prosocial values, and self-efficacy expectations, exhibited a direct association to delinquent behavior and an indirect association to drug involvement mediated by demonstrated success is using problem solving skills.
According to Compas et al. (2001) coping styles are generally considered as a protective factor for mental health. The basic idea is that some coping styles screen the individual from stressful life events, whereas other coping styles enhance the individual's vulnerability to mental health problems. Direct support for this notion in adolescent populations was provided by two subsequent studies. Results indicated that depressive symptomatology was accompanied by higher levels of passive and avoidant coping but lower levels of active and approach coping. Furthermore, evidence coming from the adult literature also suggests that depression is negatively associated with problem-focused coping but positively with emotion-focused coping.

Young (2001) examined the relationship of parent-rated early temperament to measures of adjustment, behavior problems, and health behaviors in adolescence. Results indicated a predictive relationship between parent-rated early temperament and aspect of self-reported adolescent functioning. An early temperament profile of high motor activity predicted a health-related behavior involving perceived personal support by the adolescent. High motor activity also predicted externalizing behavior problems based on parent report. The trend indicates a relationship between early patterns of high activity impacting the development of relationships with peers and adults. A negative relationship was found between the temperament characteristic approach/withdrawal and overall parent rating of emotional and behavioral functioning. Finally, adolescents with temperamental characteristics of approach and persistence contributed to the equation strongly predicting adjustment based on parent report. Parent report of approach and persistent temperament had a positive adjustment. Negative behavior was seen in withdrawal.

Hebetaling et al. (2002) opined that effective coping can be characterized by a fit between the demands of the problem situation and the kind of coping behavior. While, for example,
direct and problem oriented coping strategies are promising in controllable situations, more indirect strategies may be more adaptive in uncontrollable situations. The aim of this study was to analyze the extent to which the fit between situational demands and coping behavior is related to health-related variables in adolescence. Results revealed that the preferred use of situationally appropriate coping strategies was associated with more positive health behavior and increased well-being (functionally) in daily living. The use of inappropriate coping strategies was related to increased negative health behavior, decreased mental well-being and an increased prevalence of somatic stress symptoms.

Adolescents used more avoidance than approach coping strategies for family stressors, and more approach than avoidance strategies for school and peer stressors. Across stressors, approach coping predicted more favorable outcomes. Coping strategies in response to a specific stressor were more strongly predictive of stressor-specific adjustment than state anxiety, suggesting the need to include both stressor-specific and global measures of adjustment in assessing the relation between coping and adjustment.

Kochenderfer and Skinner (2002) examined coping strategies as potential moderators of the effects of peer victimization on children's adjustment. Self-report data on victimization experiences, coping strategies, and loneliness were collected on ethnically diverse 9-10 years old children (177 girls, 179 boys). Findings revealed that strategies such as problem solving that were beneficial for non-victimized children exacerbated difficulties for victimized children. The effects of specific forms of coping were dependent on gender: Social Support seeking buffered victimized girls from social problems but was associated with lower peer preference for victimized boys.
Matzke and Steinhausen (2002), investigated the coping strategies in a representative sample of 1,110, 10-17 year old subjects using a modified version of the Coping Across Situations Questionnaire. In line with previous research, active coping correlated positively with self-esteem, perceived parental warmth, and perceived size and efficiency of the social network. Avoidant coping correlated positively with internalizing and externalizing problems and perceived rejection by parents.

Meyer et al. (2002), conducted a study to examine the was of coping styles and locus of control contribute to the prediction of psychological adjustment in adolescent with a chronic illness. Psychological adjustment of 84 adolescent aged 13-16 years with a chronic illness was assessed with measures of social adjustment, global self-esteem and behavior problems. Linear regressions were performed with demographic factors (age and gender) and stress-processing factors (coping style and locus of control) as predictors variables. Results indicated that coping styles were related to most aspects of social adjustment. The coping styles "seeking social support" and "confrontation" were important predictors for positive social adjustment; the coping style "depression" was a predictor for poor adjustment, viz. low social self-esteem and high social anxiety. Avoidance and locus of control were not strongly associated with psychosocial adjustment.

Moos (2002) presented evidence on how personal and social resources aid adolescents in managing acute and chronic stressors, and described methods by which to assess adolescents' family environment and specific life stressors and social resources, and the approach and avoidance coping responses adolescents use to manage life stressors.

Penley et al. (2002) investigated association of coping styles with physical and psychological health outcomes using Vitaliano's coping
scale. The results suggested that avoidance coping strategy was negatively associated with overall health outcomes. Examining type of health outcomes, revealed that avoidance strategy was correlated primarily with psychological health outcomes.

The results for Problem-Focussed Coping suggested that this coping strategy was positively associated with overall health outcomes. Examining type of health outcome, however, revealed that this strategy was correlated primarily with psychological health outcomes (Penley et al., 2002). The associations with psychological health are consistent with researchers’ suggestions that this strategy is positively associated with greater psychological well-being (e.g., less depression).

The results for Wishful Thinking suggested that this coping strategy was negatively associated with overall health outcomes. Like many other strategies, however, wishful thinking was correlated primarily with psychological health outcomes. The finding for psychological health is consistent with researchers who have suggested an inverse association between wishful thinking and psychological well-being (e.g., Felton and Revenson, 1984) and a positive association between wishful thinking and negative affect.

There was no overall association between Positive Reappraisal and health in these analyses. Examining type of health outcome, however, revealed that although positive reappraisal was not significantly correlated with physical health, it was negatively correlated with psychological health. The lack of a significant association between positive reappraisal and physical health in the present analyses is inconsistent with suggestions that positive reappraisal is physical adaptive because it produces positive physiological changes. The negative correlation between positive reappraisal and psychological health in the current analyses is also inconsistent with researchers who have suggested that positive reappraisal should be associated with positive affectivity and improved psychological health (Gottlieb, 1997).
The results for **Escape-Avoidance** suggested that this coping strategy was negatively associated with overall health outcomes. Examining type of health outcome, however, revealed that escape-avoidance was negatively correlated and with psychological health outcomes, and not significantly correlated with physical health outcomes.

The results for **Planful Problem Solving** suggested that this coping strategy was not significantly associated with overall health outcomes.

The results for **Accepting Responsibility** suggested that this coping strategy was negatively associated with overall health outcomes. Like confrontive coping and distancing, however, accepting responsibility was associated primarily with psychological health outcome. The negative correlation is consistent with researchers who have reported an association between accepting responsibility and increased psychological distress and negative affectivity.

The results for **Seeking Social Support** reveal that this strategy was negatively associated with overall health outcomes. However, the moderational analyses indicated that seeking social support was actually significantly associated only with physical health outcomes and not with psychological health outcomes. The negative association between seeking social support and physical health is inconsistent with researchers who have suggested that this strategy leads to improved physical health perhaps through its association with factors such as increased immune functioning and decreased neuroendocrine responsivity. Similarly, the nonsignificant association between seeking social support and psychological health is inconsistent with general suggestions that seeking social support leads to either increased or decreased psychological well-being.

One possible explanation for the findings for social support is that the associations between seeking social support and health depend on
the nature of the support. Researchers have suggested that seeking informational support may reduce uncertainty and distress by providing an increased understanding of the situation, which may facilitate problem-focused coping. Seeking emotional support, however, could be maladaptive if individuals are seeking support to vent their emotional distress. It was impossible to explore how this distinction affected the current analyses, however, as the WOC-R seeking social support scale includes both instrumental and emotional support items, and studies did not distinguish the two forms of social support in their results.

The results for **Self-Control** suggested that this coping strategy was negatively associated with overall health outcomes. Examining type of health outcome, however, revealed that self-control was positively associated with physical health outcomes but negatively associated with psychological health outcomes. The positive association between self-control and physical health is consistent with researchers’ suggestion that self-control may improve situations or keep them from getting worse by facilitating problem-focused coping or seeking social support. In addition, the negative association between self-control and psychological health is consistent with researchers’ suggestions that self-control leads to increased psychological symptomatology. This may be because self-control is often associated with feelings of confusion and incompetence, which may lead to frustration and negative affectivity in stressful situations.

The results for **Distancing** suggested that this coping strategy was negatively associated with overall health outcomes. Like confrontive coping, however, distancing was related primarily to psychological health outcomes. The negative correlation between distancing and psychological health is consistent with previous researchers who have suggested that distancing leads to poor psychological adjustment and negative affectivity because it is usually
associated with poor situational outcomes which over time, can lead to psychological maladjustment.

However, the non significant association between distancing and physical health is in consistent with previous researchers. For example, Lazarus and Folkman (1984) has suggested that distancing, along with denial and avoidance, may be deleterious to physical health, as it may cause people to delay medical treatment or may encourage other damaging behaviors, such as increased alcohol or drug use.

The results for Confrontive Coping suggested that this coping strategy was negatively associated with overall health outcomes. Examining type of health outcome, however, revealed that confrontive coping was associated primarily with psychological health outcomes. The negative association between confrontive coping and psychological health is consistent with researchers who have suggested that confrontive coping leads to increased psychological distress and negative affectivity, perhaps because it can make a situation worse or result in strained interpersonal associations. The exception to the negative associations with confrontive coping present study was that it was not significantly correlated with physical health outcomes in chronic stressors.

Penley et al. (2002) conducted a meta-analyses and examined the associations between coping strategies and health. Their results frequently revealed reliable associations between individual coping strategies and health outcomes. Of the seven emotion-focused strategies, six demonstrated significant negative overall association with health. The exception to the negative associations authors found between emotion-focused-coping and health outcomes was positive reappraisal, which was not significantly associated with overall health outcomes in this study.

The problem-focused coping strategies demonstrated small overall associations with health outcomes, with effect sizes ranging from
-.15 (p<.05) for confrontive coping to +.08 (p<.05) for Vitaliano’s problem-focused coping. In other words, participants who reported using confrontive coping reported experiencing negative health outcomes, whereas those who reported using problem-focused coping reported experiencing positive health outcomes.

Wolfradt et al., (2003) investigated the relationship between perceived parenting styles, depersonalization, anxiety, and coping behavior in a normal high school student sample (n=276; aged 14-17 years). It was found that perceived parental psychological pressure correlated positively with depersonalization and trait anxiety among the adolescents. Perceived parental warmth was positively associated with active coping and negatively correlated with trait anxiety in the adolescents. A cluster analysis revealed 4 types of parenting styles: authoritarian, authoritative, permissive and indifferent. The group with the authoritarian parenting style showed higher scores on depersonalization and anxiety. The groups with the authoritative and permissive style of both parents showed the highest score on active problem coping.
SOCIAL SUPPORT AND TEENAGE HEALTH

Concept of Social Support

Social support has been conceptualized as the beneficial interpersonal transactions that protect people from adverse effects of stressful occurrences. Being helped is often rewarding and leads to positive feelings towards the helper. There is extensive evidence that various kinds of social support – instrumental, emotional, and social – provide benefits for health, mental health, and happiness (Lu, 1997).

Social support has been defined as “those social interactions or relationships that provide individuals with actual assistance or that embed individuals within a social system believed to provide love, care, or sense of attachment to a valued social group or dyad” (Lu, 1997). This definition eloquently encompasses the two major facets of social support that have dominated research in the last two decades: received social support and perceived social support. Received support refers to naturally occurring helping behaviors that are being provided, whereas perceived support refers to the belief that such helping behaviors would be provided when needed. In a nutshell, received support is helping behavior that did happen, and perceived support is helping behavior that might happen (Norris and Kaniasty, 1996).

Considering how parallel these aspects of support appear to be, it is surprising that they produce strikingly different effects as variables influencing the stress-to-health process. Over the years, research has proclaimed the superiority of perceived social support over received support, because it more consistently promotes psychological health and protects it in times of stress.

Implicitly, if not explicitly, explanations of the buffer effect almost always imply that the benefits of support availability operate though the
actual mobilization of support in times of stress (Norris and Kaniasty, 1996).

Wills and Cleary (1996) investigated how the effect of Social-Support is mediated. There has been a considerable amount of research showing that support from family, friends, and community networks is related to better physical health and lower levels of psychological symptomatology. Protective effects of social support among adults have been found both for structural measures such as total network size and for functional measures such as availability of emotional and instrumental support. Protective effects have also been noted for adolescents (Wills et al. 1996) Although beneficial effects of social support have been extensively demonstrated, there is less understanding of the mechanism(s) through which social support is related to outcomes. Theoretical models have suggested several mechanisms through which social support may be related to physical or mental health (Wills et al., 1996).

Theories of Support effects: What is the mechanism of Support Effect?

Three theories have been put forth to predict how functional support is related to teenage health and their problem behavior viz the stress-coping model, the deviancy model, and the differential-affiliation model.

Stress-Coping Model

Stress-Coping theory posits that social support has beneficial effects because the availability of supportive functions from other persons helps an individual to deal better with problems. In the context of adolescence, it is posited that emotional or instrumental support from parents may help adolescents to cope with problems from school, home, or family domains and may help them deal with emotional states such as anxiety, depression, or anger (Wills, et al., 1996). It is posited that when parents provide this kind of support, adolescents become
better at regulating their emotions and at problem solving. Models of resiliency effects also posit that parental support assists children to achieve good adaptation in difficult life circumstances because it contributes to the development of better competence in academic and social domains. These models predict for adolescents that parental support is related to more adaptive coping (e.g., problem solving), less maladaptive coping (e.g., coping with problems through anger), and better competence in academic tasks. Because these variables are risk factors for adolescent substance use, a mechanism is predicted in which the effect of parental support on adolescent substance use is mediated through effects on coping and competence. Implicit in this model is the suggestion that good support may help to reduce the occurrence of negative life events, which are also a risk factor for adolescent substance use (Wills et al., 1996).

**Deviancy Model**

The deviancy model proceeds from the assumption that adolescent problem behaviors are based on alienation from conventional social institutions and rejection of mainstream social values. In the theory of Jessor and Jessor (1977), a supportive relationship with parents is posited as a distal factor that may contribute to the development of deviance-prone attitudes. To the extent that an adolescent feels unsupported by his or her parents, a primary source of socialization to conventional values is lacking, and the adolescent is predicted to be less accepting of conventional social values and more disposed to deviance-prone attitudes (e.g., lower value on achievement and greater tolerance for deviant behavior). Such attitudes have been shown to be a risk factor for adolescent alcohol and marijuana use (Jessor and Jessor, 1977). This suggests a mechanism in which the relation between parental support and adolescent substance use is mediated through deviance-prone attitudes.
Differential – Affiliation Model

A theoretical focus on patterns of peer affiliation comes from the perspectives of social learning theory and sociological models of delinquency. These models (together with that of Jessor and Jessor, 1977) emphasize the importance of entry into deviant peer groups as a proximal factor for initiation of deviant behavior. The peer group is hypothesized to provide modeling and opportunity for proscribed behaviors such as cigarette smoking and to provide social reinforcement for continuation. Although all models predict a relationship between low parental support and more deviant peer affiliations, the models differ somewhat in their assumptions. Sociological models suggest that an adolescent with deviance-prone attitudes will be inclined to affiliate with deviant peers because the peers hold similar attitudes and reject mainstream values (Jessor and Jessor, 1977), the models thus predict indirect effect of parental support on deviant peer affiliations, mediated through deviance-prone attitudes. The social learning perspective, in contrast, links a nonsupportive parent–child relationship to more aversive behavior toward the child and less monitoring of the child’s behavior. This perspective suggests a direct effect from low parental support to affiliation with deviant peers. Both models agree in predicting that deviant peer affiliations will be the proximal factor for problem behaviors in teenagers.

In summary, three theoretical models provide hypotheses about how the effect of parental support on adolescent substance use is mediated. Stress-coping theory predicts that high parental support will be related to more adaptive coping, better competence, and fewer negative life events and that these will be mediators of the effects of support. The deviancy model predicts that high parental support will be related to less deviance-prone attitudes. Affiliation models predicts that high parental support will be related to less affiliation with deviant peers, either as a direct effect or as an indirect effect, and that peer affiliations
will be a proximal factor for adolescent substance use. Their study indicted that parental support was inversely related with substance abuse among teenagers.

Jou and Fukd (2002) identified different kinds of social support and defined them as follows:

Support provided for others: The amount of support that the participant provides for others.

Support received from others: The amount of support that the participant receives from others.

Support requested by others: The amount of support that others request from the participant.

Support requested of others: The amount of support that the participant requests of others.

Reciprocity of support - The condition in which (a) the support that the participant receives from others is almost equal to the support that the participant provides for others or (b) the support that others request from the participant is almost the same as the support that the participant request from others. Over benefited and Under benefited:

Receiving more support than one provides and providing more support than one receives respectively.

Sufficiency of support: The condition in which (a) the support that the participant receives from others is almost equal to the support that the participant requests from others or (b) the support that the participant provides to others is almost equal to the support that others request from the participant.

Heaven (1996) reported about the relationships between different family climates and the resultant coping behaviours in adolescents. In an unstructured conflict oriented family climate, with high degree of conflictive interaction; lack of support within family; no support for personal growth, the adolescents exhibited high level of dysfunctional coping characterized by withdrawal and passivity. A control oriented
family climate is characterized by structured family activities; explicit
family rules; emphasis on achievement; supportive family but do not
allow children to express emotions. In such climate, adolescents tend to
be passive and they rely on family decisions. In an unstructured
expressive-independence oriented family climate which is cohesive and
unified, feelings are expressed; individual independence is supported
and there is no pressure to achieve, the adolescents plan course of
action and turn to others for advice and information. There is lot of
emphasis on family relationships in a structured expressive-intellectual
oriented family climate. Moreover, independence is encouraged and
there are clear rules. Here also, the adolescents turn to others for
advice and information and they plan course of action.

According to Miyazaki et al., (2003) social support has been
proved to have effects on mortality and incidence of diseases. It is
believed that Social support has even stronger effects on mortality than
other risk factors like smoking and Type A behaviour. It is also known
that social support has effects on psychological parameters such as
depression and anxiety.

Although researchers in various fields have shown that social
support influences the status of one’s health, the mechanisms through
which social support has its effects remain to be determined and many
proposals have been put forth. Heaven (1996) proposed that social
support has an effect on one’s appraisal of stressors. Consequently
social support indirectly affects stress reactions such as anxiety and
depression. Another observation is that social support indirectly
influences health via direct influences on health-related behaviours such
as physical exercise. The above two pathways can be classified into the
hypothesis of indirect effects. On the other hand, the direct effect
hypothesis is also represented as there is some evidence relevant to
direct effects of quality of social relationships on immune function in the
field of psychoneuroimmunology. They concluded that social support
has a substantial relationship to immune function on the basis of meta analysis in the investigation of social support.

Many studies have been conducted to examine the relationship between perceived social support and health.

Cohen and Wills (1985) stated that perceived support may serve as a stress buffer by influencing individual's interpretation of stressors, knowledge of coping strategies, and self-concept.

Dhoundiyal (1984) studied the effect of home environment on the emotional disturbance among adolescents. In general, it was revealed that poor home environment led to significantly more frequent occurrences of emotional disturbances among teenagers.

In a study by Compas, et al., (1986), a number of factors that could moderate the life events-illness relationship were examined. First, perceived social support was found to be associated with symptomatology. More specifically, lower levels of satisfaction with social support were significantly related to symptoms of depression, somatization, interpersonal sensitivity, and anxiety.

The relationship between ties to one's family and one's personality and well-being has long been a question of interest in developmental psychology. Recently, there has also been a growing recognition of the increasing importance of extrafamilial relationships through childhood and adolescence. In the present study, the attachment relationships of older adolescents to their parents and peers, and their differential association to well-being was examined. (Armsden and Greenberg, 1987).

The results of two studies by Armsden and Greenberg(1987) were as follows: The sample comprised of 179 students aged 16-20 years. As hypothesized, perceived quality of both parents and peer attachments was significantly related to psychological well-being. Results of the development of a theoretically focused, exploratory classification scheme indicated that adolescents classified as highly
securely attached reported greater satisfaction with themselves and less symptomatic response to stressful life events.

A study by Raja, et al., (1992) reported the findings from a study of 935 adolescents’ perceived attachments to their parents and peers, and their psychological health and well-being. Perceived attachment to parents did not significantly differ between males and females. However, females scored significantly higher than males on a measure of attachment to peers. Also, relative to males, they had higher anxiety and depression scores suggesting poor psychological well-being. Overall, a lower perceived attachment to parents was significantly associated with lower scores on the measures of well-being. Adolescents who perceived high attachment to both their parents and peers had the highest scores on a measure of self-perceived strengths. In this study, adolescents’ perceived attachment to peers did not appear to compensate for a low attachment to parents in regard to their mental ill-health. These findings suggest that high perceived attachment to parents may be a critical variable associated with psychological well-being in adolescence.

Gribble, et al. (1993) reported the parent and child views of Parent – Child Relationship Qualities and Resilient Outcomes among urban children. Separate in-depth interviews were conducted with two groups of highly stressed 4th – 6th grade urban children classified as stress-affected (SA) and stress-resilient (SR) and their parents. Judges identified interview items reflecting three components of a good parent-child relationship, i.e. positive parental attitudes, involvement and guidance. Stress-resilient parents and children scored higher than their stress-affected counterparts on all three relational dimensions. Additionally, stress-resilient parent-child dyads had more congruent views of their relationship than stress-affected dyads. These findings suggest that positive parent-child relationship qualities play an important protective role that favors resilient outcomes.
Hoffman et al., (1993) reported on the basis of their study, considerable impact of social forces on the quality of self-esteem in adolescence. Affirmation and approbation from parents and peers do appear reflected in the adolescents' own view of themselves.

Clara, et al. (1994) administered an adolescent health survey to 1,683 7th-12th graders with a variety of chronic conditions and 1,650 7th-12th graders without chronic conditions to determine emotional well-being, worries and concerns, and body image. Subjects with chronic conditions had lower emotional well-being scores, worried more about dying soon and about school or future work, and had poorer body image. For all subjects, higher emotional well being scores were significantly related to higher levels of family connectedness. The best explanatory variables of emotional well being were body image, family connectedness, concerns about school and future work, having a disability, and worry about peer relationships, accounting together for 36% of the variance in the outcome variable.

Juon, et al. (1995) examined the prevalence of cigarette smoking and studied its relationship with individual, family, school and psychological factors among Korean adolescents. As part of the Korean Institute for Health and Social Affairs' Adolescent Health Survey, 5209 8th graders and 4677 11th graders (5,009 males and 4,877 females) completed a self-administered questionnaire. Current prevalence of cigarette smoking was 8.45%. Smoking prevalence increased with age among boys. Based on logistic regression analyses, perceived peer use was most strongly associated with smoking status. Academic stress, grade, and type of school were also associated with smoking status for both boys and girls. In addition, mothers' smoking, birth order, and urbanity were associated with smoking status for boys.

McFarlane, et al. (1995) examined the influence of family disruption on adolescent well-being (n = 801). A caring, empathic parenting style correlated with the best family functioning and
adolescent well-being. This style of parenting was found to be independent of family structure. The contribution of both parents to family functioning and adolescent well-being was important, especially to children of the opposite sex.

Heaven (1996) said that many researchers have examined the role of the family in maintaining substance use among teenagers and have shown that father characteristics have additive effects with the teenagers’ personality in predicting substance use. They opined that child-rearing practices were important in shaping the adolescents' drug-using behaviour. In particular, the nature of the bond between parent and teenager as well as the emotional warmth and responsiveness of the parent are crucial factors. The researchers also found that the nature of attachment was more important in predicting drug behaviour than factors such as parental control (Brook et al., 1987).

According to Heaven (1996) adolescent self-esteem appears to a large extent dependent upon parenting style and, together, they act as antecedents for depression. In one study it was found that parental rejection, rather than factors such as family conflict or family religiosity, was important in determining adolescent depression (Robertson and Simons 1989). More specifically, parental rejection was found to predict depression in those homes where parents failed to nurture adolescents' self-esteem by providing a warm and caring family environment. Thus, family dynamics do influence adolescent depression through adolescent self-esteem.

Radziszewska, et al. (1996) examined whether the relationship between parenting styles and adolescent depressive symptoms, smoking, and academic grades varies according to ethnicity, gender, and socioeconomic status. Four parenting styles were distinguished, based on patterns of parent-adolescent decision making: autocratic (parents decide), authoritative (joint process but parents decide), permissive (joint process but adolescent decides), and unengaged
adolescent decides). The sample included 3993, 15-year-olds (Whites and Asians). Results were consistent with previous findings i.e. adolescents with authoritative parents had the best outcomes and those with unengaged parents were least well adjusted, while the permissive and the autocratic styles produced intermediate results. For the most part, this pattern held across ethnic and sociodemographic subgroups. There was one exception, suggesting that the relationship between parenting styles, especially, the unengaged style, and depressive symptoms may vary according to gender and ethnicity.

The authors said that the finding that Asian girls were likely to have elevated level of depressive symptoms if their parents were either unengaged or autocratic also deserves a follow-up investigation. There is no information currently available to speculate as to why Asian girls are particularly likely to experience depressive symptoms if their parents exercise either excessive or minimal control.

Ratti, et al., (1996) compared perceived relationships and interaction patterns among 44 families with externalizing (polydrug-dependent), internalizing (bulimic), or normal adolescent daughters. Results revealed that families of polydrug-dependent girls were less well attached and less autonomous than were families of daughters with bulimia who were, in turn, less attached and autonomous than controls.

Helsen, et al. (1997) studied the relationship between parental and friends’ social support of school-age children, adolescents, and young adults, with emphasis on emotional problems, adolescent development, and male-female differences (n = 1353, school students). Changes in relationships and the effects of family support vs peer support affected emotional problems and coping strategies. Su et al., (1997) studied the relation of parental mental health with healthy eating habits of adolescents. Results revealed that adolescents whose parents had substance abuse disorder had lower intake of fruits and higher intake of high fat foods, and also ate more frequently at fast-food
restaurants and purchased more snacks. Adolescents whose parents were depressed had lower intake of all food groups. Mother’s mental health status impacted more on adolescents’ dietary behaviors than did the father’s mental health status. This research suggests that at-risk behaviors among youth of psychiatrically impaired parents extends to healthy/unhealthy eating behavior.

Hoffman, et al., (1998), assessed contingencies in the effect of social support from parents and friends on adolescent self-esteem. Questionnaires were administered to 76 Israeli adolescents regarding self-esteem, stressful life events, and perceived level of support from mother, father, and friends. Maternal support had a strong effect on self-esteem. Aid from friends was influential primarily when that of mothers’ was absent. Paternal support had little effect, once other support sources were controlled. Despite the negative influence of stress on self-esteem, support and stress had no interactive effects. These findings, consistent with attachment theory and social provision theories, were contrary to cross-pressure or separate world models of peer parent influence.

Kenny, et al. (1998) examined the relations between adolescent ratings of parental attachment (affective quality of parental relationship and parental fostering of autonomy) and self-reported psychological well-being over the 1-year period from the eighth to the ninth grade. Through structural equation modeling, relations between adolescent perceptions of parental attachments and psychological well-being (positive view of self and low levels of depressive symptoms) at Grades 8 and 9 were tested separately for girls and for boys. Adolescent ratings of maternal and paternal attachment at Grade 8 contributed to changes in well-being 1 year later for boys only. Adolescent boys ratings of well-being at Grade 8 were associated with changes in ratings of attachment to father from the eighth to the ninth grade.
Bao, et al., (2000) examined the effectiveness of social support network on psychological well-being among 602 homeless and runaway adolescents. The respondents were interviewed in shelters, drop-in centres, and on the streets in cities of four Midwestern US states. The path model was used to test the direct effect of family abuse and precocious independence on adolescent depressive symptoms and indirect effects through social support networks. Results indicated that although abusive family origins contributed directly to depressive symptoms, there were indirect effects of family abuse and early independence through social support networks. Family abuse and early independence drive homeless adolescents to rely on peers for social support. While support from friends on the streets reduces depression, association with deviant peers increases depression.

Markestorm, et al., (2000) attempted to examine social support and coping in relation to resiliency among a sample of rural, low-income adolescents. Utilizing regression analyses, it was shown that social support from family and problem focused, avoidance, and wishful-thinking forms of coping significantly predicted resiliency.

Sastre and Ferriere (2000) investigated to what extent adolescents’ subjective well-being was affected by breaking down of the family. Results revealed that broken family structure had considerable negative impact on adolescent well being.

Bary (2001) reported that overall stress, family conflict and parental monitoring interacted with separation; and stress interacted with intergenerational individuation to predict increases in adolescent alcohol use over time.

Biesecker (2001) reported that close relationship with parents and friends plays an important role in adolescents’ feelings about themselves and how they express and regulate emotions. According to attachment theory, open and flexible communication between parents and children around emotion signals promotes more adaptive emotion
regulation. Security of attachment in the family provides a template for later close relationships. Hierarchical regression equations including attachment to mothers, fathers, and peers as predictors explained 54% of the variance in emotion regulation, but only attachment to fathers and peers emerged as significant. Adolescent feedings of alienation from their fathers appeared to be particularly relevant.

Cattelino et al. (2001) studied the relationship between family functioning and family structure and the effects of both factors on the psychological well-being of adolescents and young adults (n = 2259). The results revealed that authoritative parenting style was a major contributor to positive self-perception and optimism among 14-15 year olds, whereas parental support was a major contributor to these areas among 18-19 year olds.

Childs et al., (2001) examined the relationships of maternal depression, family stress, child social skills, and child social competencies on adolescent adjustment. The sample included 50 mothers (mean age 40.91 years) with at least one child between the ages of 1 and 14. It was hypothesized that maternal depression and family stress would predict adolescent adjustment. Maternal depression accounted for half the variance (52%) in child adjustment. Family stress variables were significantly correlated with child adjustment, but they failed to significantly add to the regression equation. The 2nd hypothesis was that the adolescents' social competence would independently account for additional variance beyond that associated with maternal depression. This hypothesis was clearly supported. Three of the six measures of social skills and competencies significantly added to the predictability of child adjustment. Maternal depression and social competency variables combined to account for a total of 74% of the variance in child adjustment within the sample. Maternal depression was a risk factor for adolescent maladjustment, while, social competence was related to resilience.
Spruijt et al. (2001) studied the well-being of teenagers coming from six different family types. Increasing number of children grow up in family forms other than a nuclear family with both a biological father and mother. This study examined intact families that differ in functioning (functioning well, mediocre, or badly), one-parent families, stepfamilies after a divorce, and single-parent families after being widowed to determine possible effects of family form and family flux on the well-being of adolescents and young adults. Compared to teenagers of well-functioning nuclear families, the subjects of discordant nuclear families showed worse physical and mental health, their parental fixation was not as strong, and they tended to drink more alcohol, smoke more cigarettes, and use more soft drugs. Children of divorced families were notable for their relational behavior: they entered into relations at an early age, usually were more sexually experienced, and reported more relational problems. Children of widowed, one-parent families did well. In other family types girls suffered a little more from the burden of life than boys.

Jou and Fukda (2002) examined the effects of reciprocity and sufficiency of social support on the mental and physical health of 488 Japanese University students with different levels of stressors. It also addressed negative affect associated with support relationships, as well as the levels of stressors and mental and physical health. The participants' support relationships with others were fairly reciprocal. Although being overbenefitted (i.e. receiving more support than one provides) was related to stronger feelings of indebtedness, being underbenefitted (i.e. providing more support than one receives) was related to stronger feelings of burden. In sum, when the participants received less support than they requested and when they provided less support than others requested, they tended to become less mentally and physically healthy. Reciprocity of support appeared to have both
direct and buffering effects. However, the effects of sufficient support on health did not vary with levels of stressors.

Purohit and Mehta (2002) studied the relationship between perceived parental behavior and personality types among school going adolescents (n = 240). The obtained results seemed to give more emphasis on father’s role in determining extraversion among the adolescent children.

Sartor and Youniss (2002) examined the relationship between positive parental involvement and identity achievement during adolescence. Parental support and provision of structure were linked to positive outcomes in adolescents.

Colarossi and Eccles (2003) examined the differential effects of parent, teacher, and peer social support on depression and self-esteem of 217 adolescents, aged 15-18 years. The results indicated that female adolescents perceived significantly more support from friends than male adolescents did. Boys and girls perceived the least amount of support from fathers compared with other providers. Multi-sample structural equation models were invariant across female and male groups for the effects of support providers on each outcome. A significant amount of variance in depression and self-esteem suggested that social support has important effects on symptoms. Self-esteem was significantly and positively affected by friends’ and teachers’ support.

Galambos, et al (2003) examined the relative influence of three parenting behaviors (support, behavioral control, and psychological control) and deviant peers on trajectories of externalizing and internalizing problems in early adolescence. A white working – to – middle – class sample of adolescents and their mothers and fathers in double-earner families participated in a three and a half year longitudinal study (N = 109 families). The study began when the adolescents were in 6th grade (mean age = 11.5 years). Analyses showed that parents from behavioral control seemed to halt the upward
trajectory in externalizing problems among adolescents with deviant peers. Initial levels of internalizing problems were higher among adolescents with parents who reported lower levels of behavioral control and among adolescents with deviant peers. This study implies that parents exert an important influence in adolescents' lives and may do so even in the face of potentially negative peer influence.

Leinonen et al. (2003) examined the specificity of interpersonal relationships mediating symptoms of mental health problems. Information about parent and child mental health, marital interaction and parenting was received from 527 mothers and fathers. Information about child mental health was also received from 12 year old children (260 girls and 267 boys). The results confirmed that parental mental health problems can compromise a mother’s and father’s parenting abilities and represent a threat to their children’s adjustment. The results suggested that the different types of parental mental health problems initiate specific paths between parental and child mental health problems. The results further suggested that opposite sex parenting is important to children’s adjustment during the years of early adolescence.
NEGATIVE AFFECT AND TEENAGE HEALTH

Two indices of negative affect have been included in the present study viz. Anger and Depression.

Emotions as causes and sequel of health and disease play a central role in psychoanalytic theories. Stress-related emotions now are central concepts in theoretical perspectives in behavioral health. Stress-related emotional arousal is assumed to adversely affect health and is considered an etiological factor in disease processes. Sweeping advances have been made linking stress-related emotional arousal and the potentially harmful physiological cascade of events that follows its instigation. Anxiety, depression, anger and hopelessness are the common negative emotions found to play a major role in health and illness (Susman et al., 1992).

Anger, Anger Expression Styles and Teenage Health

Anger is a negative and destructive human emotion. Anger is a very important psychological construct and plays a prominent role in health especially cardiovascular health.

According to Linder et al. (1997), trait anger and hostility as well as poor anger coping (i.e. aggressive responding and habitual retention of anger) has been linked to an increased risk for cardiovascular diseases.

According to Baron (1977) anger is a negatively toned emotion, subjectively experienced as an aroused state of antagonism towards someone or something perceived to be the source of an aversive event. It is triggered or provoked situationally by events that are perceived to constitute deliberate harm doing by an instigator towards oneself or towards those to whom is endeared. Provocation usually take the form of insults, unfair treatment, or intending thwarting. Anger is prototypically experienced as a justified response to some ‘wrong’ that has been done. Although anger is situationally triggered by acute,
proximal occurrence, it is shaped and facilitated contextually by conditions affecting the cognitive arousal, and behavioural system that comprise anger reactions. Anger activation is centrally linked to threat perception and survival responding (Baron, 1977).

According to Spielberger (1988), “The concept of ‘Anger’ refers to emotional state that consists of feeling that varies in intensity, form mild irritation or annoyance to intense fury and rage. Although ‘hostility’ usually involves angry feelings, this concept has the connotation of the complex set of attitudes that motivates aggressive behaviours diverted towards destroying objects or injuring other people. While anger and hostility refer to feelings and attitudes, the concept of ‘aggression’ generally implies destructive or punitive behaviour directed towards other persons or objects.

Expression of Anger

Spielberger (1988) gave three anger expression styles viz Anger Out, Anger In, Anger Control. Individuals may be classified as Anger-Out if they express anger towards other person or objects in the environment that is called ‘anger out’. It generally involves an increase in state anger and the manifestation of aggressive behaviour. Anger directed towards others may be expressed in physical acts, such as assaulting other person, destroying objects and slamming doors, verbal threats and the extreme use of profanity (Spielberger 1988).

Persons who direct anger inward, towards ego or self or who hold in (suppress) the anger are classified as ‘Anger in’. With psychoanalytic conception, thoughts and memories relating to anger provoking situations and even feelings of anger, themselves may be repressed or denied. But in contrast, the suppressed anger is consciously experienced as an emotional state, i.e. anger varying in intensity and fluctuating over time as a function of the provoking circumstances (Spielberger 1988). ‘Anger Control’ refers to how much an individual can control his angry feelings and maintain calm and composure.
Fang (1997) reported that African Americans are at greater risk for hypertension than Whites and other ethnic groups in the United States. Although the reasons for this are unknown, it has been argued that exposure to chronic stress contributes to the development of hypertension.

Fang (1997) examined the role of anger in cardiovascular reaction in adolescents. He found that both the anger-provoking/nonracial film excerpts elicited large increases in cardiovascular reactivity measures and emotional distress (e.g., anger and anxiety) in African American participants. White participants showed the largest increases in cardiovascular reactivity measures in response to the anger-provoking/nonracial clip. In addition, results indicated that hostile African American males had significantly greater increases in blood pressure than low hostile African males.

Sonnega (1997) said that anger has been identified as a risk factor for cardiovascular disease and violence. The population consisted of 260 adolescents from two schools in Baltimore. Anger was associated with interpersonal motives, both social dominance and intimacy goals, rather than personal motives. Deficits in social skill, both broad and specific, were related to greater trait anger. The tendency to anticipate interpersonal threats during school (a ‘hostile attribution bias’) was also related to anger.

The results of this study reflected multiple social cognitive processes by which goals and skills may generate anger: goal blockage, goal content, goal norm violations, broad and domain specific social skill deficits, skill tendencies or biases, and norm skill violations. The social contextual model of anger allows for the integration of these diverse phenomena, and suggest that anger is a ‘syndrome’ composed of multiple components. Information derived from this study may increase the ability to intervene in a meaningful way before anger becomes problematic in adolescents.
Novaco (1995) examined the relationship between asthma in teenagers and anger and hostility and found a positive association between the two. Joshi (1999) also found similar results.

Robert et al. (2002) explored risk factors and behaviours associated with aggressive and violent behaviours among adolescents. A comprehensive review was conducted of research literature from various disciplines associated with improving the health and well being of adolescents. Risk factors and behaviours associated with adolescent aggression and violence are discussed via 6 major factor categories: individual, family, school academic, peer related, community and neighborhood and situational. It is concluded that adolescent aggression and violence develops and manifests within a complex constellation of factors.

According to Buss (2000) depression is one of the most common psychological maladies of modern humans, and it afflicts roughly twice as many women as men. There is some evidence that rates of depression are increasing in modern life. Five studies comprised of 39,000 individuals living in five different areas of the world revealed that young people are more likely than older people to have experienced at least one major episode of depression (Nesse and Williams, 1994). Moreover, the incidence of depression appears to be higher in more economically developed cultures (Nesse and Williams, 1994). Why would rates of depression be rising in modern environments, despite the greater abundance of creature comforts and the presence of technological solutions to former ancestral maladies of life, asked Buss (2000). He reported one hypothesis put forth by Nesse and Williams (1994).

Nesse and Williams (1994) opined that:

"Mass communications, especially television and movies, effectively make us all one competitive group even as they destroy our more intimate social networks.... In the ancestral environment one would have had a good chance at being the best at something. Even if
one were not the best, one’s group would likely value one’s skills. Now we all compete with those who are the best in the world. Watching these successful people on television arouses envy. Envy probably was useful to motivate our ancestors to strive for what others could obtain. Few of us can achieve the goals envy sets for us, and none of us can attain the fantasy lives we see on television (Nesse and Williams, 1994).”

According to this analysis, the increase in depression stems from self-perceived failures resulting in erroneous comparisons between people’s lives and the lives they see depicted so glamorously in the media. A related explanation of an increase in depression invokes the fact that modern living conditions of relative anonymity and isolated nuclear families deprive people of the intimate social support that would have characterized ancestral social conditions (Nesse and Williams, 1994).

Depression is projected to be the second leading cause of disability by the year 2020. In India, clinically recognizable depressive disorders have been found to be as common as in the West (Sharma et al., 2001).

Depression is common among teenagers also. Epidemiological studies have reported prevalence of depression in teenagers ranging between 0.4 and 8.3%. Furthermore, lifetime prevalence of depression in adolescents/teenagers varies between 15 and 20% which is comparable with the life time range in adults, suggesting that depression frequently has its onset in adolescence (e.g. Lewinsohn, et al., 1986).

According to Joyner and Udry, (2000) absence of depression is an indicator of teenage well-being. Depression has been found not only to influence the self-esteem of adolescents, but also their suicidal thoughts and behavior. Depression additionally increases adolescents’ chances of experiencing academic and inter-personal problems. These problems in turn increase depression, creating an ongoing cycle.
Depression in adolescence has even been linked to outcomes in young adulthood, including depression, early marriage, and marital dissatisfaction.

In contrast to early adulthood, teenage is a period during which levels of depression increase, especially for females. Although males exhibit higher levels of depression than females during childhood, females display higher levels of depression during adolescence.

Those who work in the area of teenage depression tend to use a classificatory system that is based upon the adult version. In a recent review, Petersen and her colleagues (Petersen, et al., 1993) suggested the following types of depressive disorders among teenagers:-

- Depressed mood
- Depression syndrome
- Clinical depression

In depressed mood teenagers report having the ‘blues’ or report feeling sad and down. Such feelings are usually triggered by an external source, for example a bad grade at school or the break-up of a special relationship. The depressed mood may be quite brief (a day or so) or may extend for a much longer period. According to Petersen and colleagues (1993), other symptoms are also very often associated with depressed mood and these may include fear, guilt, anger, contempt, disgust, anxiety, or social withdrawal.

Aspects of teenage depression can be viewed as part of a wide range of related problems that form part of a behavioral syndrome (Petersen et al., 1993). Several research studies have suggested that depression co-exists along with anxiety, feelings of loneliness, a fear of doing bad things, and a fear of being unloved. Additional components can also include a feeling that others might be out to ‘get’ you, feelings of worthlessness, nervousness, guilt, etc.
Clinical depression coincides with major depression and dysthymia in adults. To be diagnosed with major depression, a teenager must have experienced five or more of the following over a two-week period (Petersen et al., 1993):

- Depressed mood or irritable mood most of the day
- Decreased interest in pleasurable activities
- Changes in weight or perhaps failure to make necessary weight gain in adolescence
- Sleep problems
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feeling of worthlessness or abnormal amount of guilt
- Reduced concentration and decision-making ability
- Repeated suicidal ideation attempts, or plans of suicide

For a teenager to be diagnosed with a dysthymic disorder, evidence of a depressed or irritable mood needs to be present for nearly every day for almost a year. In addition, at least two of the following need also to be present (Petersen et al., 1993):

- Eating problems
- Sleeping problems
- Lack of energy
- Low self-esteem
- Reduced concentration or decision making ability
- Feeling of hopelessness

**Emotions, their Expression and Health Outcomes**

The extent to which people suppress or display their emotions has been traditionally related to several health and disease outcomes. Two theoretical approaches have been adopted in an effort to establish a pattern of relationships between emotional experience and health: The "non-expression" and the "expression approach". According to the
“non-expression approach”, people who inhibit their emotions are more prone to disease than those individuals who are emotionally expressive (Gross and Levenson, 1997). Empirical attempts to test this hypothesis have tried to explore the negative effects of emotional inhibition on physical and psychological well-being. Based on this research paradigm, hostility and anger suppression have been related to essential hypertension and coronary heart disease (Weidner et al., 1989). Empirical evidence has related type C inhibitory personality style to the pathogenesis of cancer. A considerable amount of empirical reports has further shown a link between avoidant, and defensive coping strategies and decreased immune functioning (Schwartz and Kline, 1995).

More recently, researchers have focused on the “expression approach”, and have tried to explore the beneficial health effects of emotional expression (Greenberg et al., 1996). Recent work by Pennebaker (1993) has suggested that disclosure of inhibited emotions. Talking or writing about personal experiences has been reported to result in changes in autonomic and muscular activity, enhanced immune functioning (Pennebaker et al., 1988), fewer visits to medical centers (Pennebaker and Hoover, 1986), and fewer self-reports of physical symptoms (Greenberg and Stone, 1992). In a recent meta-analysis Smyth (1998), reported that emotional disclosure (induced using different variations of the writing task) was found to lead to significantly improved health outcomes.

Beck et al., (1990) conducted a study showing that a generalized negative view of the self is a distinguishing feature of depression. They used a non clinical sample, a stringent test of specificity in view of the high overlap of depressive and anxiety symptoms measure from which overlapping content had been removed. They, related self-concept to positive with negative affectivity (PA, NA). Specificity to depression suggested that low self-esteem should be linked especially to high
Negative Affectivity. Results indicated that self-esteem was (a) inversely correlated with depressive symptoms, (b) specific to depressive symptoms, and (c) correlated more highly with Positive Affectivity than with Negative Affectivity.

According to Chang et al., (1998) research over the years has shown that hopelessness or the lack of hope can have serious and sometimes detrimental effects on one's health and well-being. More recently, however, researchers have begun to express interest in examining the potential positive effects of hope for promoting psychological and physical well-being.

Implicit in Snyder's model is the notion that hope represents a general disposition to engage in conscious efforts to obtain an end or a goal. If this view is accurate, then hope should be significantly related to problem-solving ability or activities that involve problem-solving. In support of this view, Snyder et al., (1991) found a significant but moderate correlation between the Hope Scale (HS) and the Problem-Solving Inventory. In addition, Snyder et al., (1991) found that Hope scores predicted a significant amount of the variance in problem-focused coping efforts even after controlling for the influence of other important individual-difference variables, including negative affect and dispositional optimism.

Buntaine et al., (1999) said that the belief that early aggressive behavior places children at-risk for negative outcomes is substantiated by empirical research. Those children who display extreme levels of aggression have been found to be more likely to require higher levels of mental health intervention, to be more likely to become juvenile delinquents, to have higher rates of school drop outs. To demonstrate lower levels of academic achievement and to be rejected by their peers (Coie, et.al., 1992). Because of the relationship between anger and aggression, the emotion of anger also may have largely negative
consequences for both the individual and society in terms of promoting illness and negating health.

Shinn (1999) conducted a study to investigate whether depression or anxiety or both are related to the development of elevated blood pressure after four years in initially nonhypertensive adults. It was hypothesized that depression and anxiety would both be significantly related to the development of elevated blood pressure, independent of baseline blood pressure, age, sex, parental history of hypertension, and Body Mass Index. Multiple regression analysis indicated that depression and anxiety were significantly but negatively related to changes in diastolic blood pressure, that is, participants who were depressed or anxious at baseline are more likely to have lowered diastolic blood pressure after four years. Furthermore, depression and anxiety were negatively related to changes in diastolic blood pressure for obese participants and not non-obese participants. These findings do not support the hypothesis that depression and anxiety are psychosocial precursors to elevated blood pressure.

Danner et al., (2001) conducted a study on handwritten autobiographies from 180 Catholic nuns, when participants were of mean age of 22 years. Autobiographies were scored for emotional content and related to survival. A strong inverse association was found between positive emotional content in these writings and risk of mortality in late life (p<.001). As the quartile ranking of positive emotion in early life increased, there was a stepwise decrease in risk of mortality resulting in a 2.5-fold differences between the lowest and highest quartiles. Positive emotional content in early-life autobiographies was strongly associated with longevity even six decades later.

A growing body of literature has shown positive and negative emotion-related attitudes and states to be associated with physical health, mental health, and longevity. For example, in a longitudinal study of Harvard graduates, (Peterson et al., 1988) found the ways in
which young men explained bad events predicted health outcome decades later. Such studies appear to be based on assumptions that emotion-based constructs reflect patterns of coping with negative life events and stresses that can be harmful or beneficial to health.

Danner et al., (2001) further reported that over the past 30 years, emotion researchers have identified basic emotions such as happiness, sadness, anger, fear, and disgust. More recently, these basic emotions have been associated with differentially patterned autonomic nervous system (ANS) responses. The functional characteristics of the associated patterns of emotion and autonomic nervous system activation strongly suggest the potential for a lifelong pattern of emotional arousal affecting health and longevity. Furthermore, numerous studies have shown the complex emotional states, such as anxiety, produce elements of autonomic nervous system patterns associated with specific negative emotions. These same elements of elevated galvanic skin response, heart rate, and blood pressure and found in the patterned autonomic nervous system responses to the arousal of basic emotions and potentially could affect health and longevity. Laboratory research also has found that the suppression of emotional states can exacerbate autonomic nervous system responses. A lifelong pattern of suppressing the expression of emotion has the potential for adverse effects on essential body systems. Although no autonomic nervous system pattern has been found to be associated with positive emotion that differentiates it from baseline, studies have demonstrated the potential muting effects of positive emotions on the bodily responses to negative emotion (Fredrickson and Levenson, 1998). This healing effect of positive emotion may have the potential to reduce stress on the cardiovascular system even in the face of inevitable negative life events. In other words, constructs such as optimism and positive attitude may imply the following sequence: Events arousing negative affect are approached with confidence that
the future holds something positive and better, thus internally generating a positive emotional state that mutes the adverse effects of the prolonged arousal of a negative emotion.

Danner et al., (2001) findings strongly associated with recent longitudinal studies that suggest that optimism is associated with longer life (Maruta et al., 2000).

Pettit et al., (2001), reported that a number of empirical investigations suggest that positive emotions (positive affect) may be useful and salutary in a variety of settings. For instance, positive affect may favorably impact variables such as learning, creativity, problem solving, and relationship formation. The benefits of positive affect have also been demonstrated in clinical settings. In an investigation of individuals experiencing suicidal symptoms, Joiner et al., (2000) found that an index related to positive affect predicted decreased suicidal symptoms via increased problem-solving ability. Therefore, it appears that positive emotional states may produce profitable outcomes in multiple areas, ranging from the enhancement of learning to the amelioration of psychological distress.

Anderman (2002) examined school level differences in the relation between school belongingness and various outcomes. The relations between belongingness and psychosocial outcomes were examined. Individual students perception of belongingness were inversely related to depression, social rejection and school problems.

According to Nyklicak et al., (2002) in lay beliefs and folk psychology the expression of emotions, including crying is often considered to be beneficial for one’s health. Accordingly, inhibition and repression of emotions is believed to result in maladaptive chronic activation of the body and consequently, ill health.

Non-expression of emotions seems to be a crucial element of many personality features which have been related to health, including alexithymia (Sifneos, 1973), defensiveness repression (Weinberger et
al., 1979), Type C (Temoshok et al., 1985) and Type D (Denollet et al., 1996) coping styles. Even negative affectivity (Watson and Pennebaker, 1989) can be considered to have an important emotional expression component.

Research on emotional (non) expression is characterized by two facets; it has mainly focused on healthy individuals and it has failed to explore the relationships between the different concepts describing expression and non-expression. Panagopoulou et al., (2002) conducted a meta-analysis in order to identify the differential effects of emotional expression and non-expression in patient samples. Results showed that neither expression, nor non-expression of emotions was related to perception of disease severity. Psychological distress increased in relation to emotional non-expression, but no effect was shown for emotional expression. Emotional non-expression was also related to adopting a helpless attitude towards the disease.
What is Optimism

A useful definition of optimism was offered by anthropologist Lionel Tiger (1979). He defined optimism as "a mood or attitude associated with an expectation about the social or material future – one which the evaluator regards as socially desirable, to his (or her) advantage, or for his (or her) pleasure" An important implication of this definition, is that there can be no single or objective optimism, at least as characterized by its content, because what is considered optimism depends on what the individual regards as desirable. Optimism is predicated on evaluation – on given affect and emotions, as it were (Peterson, 2000).

According to Raikkonen et al., (1999) Optimists are people who expect positive outcomes. As a consequence, they expect to cope effectively with everyday stress and challenge, whereas pessimists are those who expect negative outcomes and do not expect to cope successfully (Scheier and Carver, 1992). Optimists are likely to persist in their goal-directed efforts, whereas pessimists are more likely to withdraw effort, become passive, and potentially give up on achieving their goals. As such pessimists are hypothesized to be more likely to experience the physical and emotional consequences of stressful situations than are optimists.

According to Scheier and Carver (1985) pessimism refers to the tendency to expect negative outcomes in the future. Although fatalism formally refers to the belief that outcomes (both good and bad) are predetermined, in the context of existing research on illness and disease, it typically refers to the belief that the worst of all possible consequences will come to pass. As such, both pessimism and fatalism
share a common core that involves negative expectations regarding future outcomes.

Scheier and Carver (1992) studied the personality variable they labeled as dispositional optimism: the global expectation that good things will be plentiful in the future and bad things, scarce.

Buchanan and Seligman, (1995) have approached optimism in terms of an individual’s characteristic explanatory style: how individual’s explain the causes of bad events. Those who explain bad events in a circumscribed way, with external, unstable, and specific causes, are described as optimistic, whereas those who favor internal, stable, and global causes are described as pessimistic.

According to Goodman et al., (1997) although optimism is generally viewed as a positive attribute, this trait has received little systematic evaluation among Teenager. Optimism is defined as the tendency to believe one will experience positive outcomes in life. In studies of adults, optimism has been associated with beneficial health effects. Among college students, higher optimism has been associated with better adjustment to college and higher expected levels of academic achievement. However, higher optimism was positively correlated with sexual risk behaviors among human immunodeficiency virus (HIV)-negative homosexual men and less use of HIV testing services among female adolescents engaging in risk behaviors (Goodman et al., 1997).

Hasan et al., (2002) investigated the relation between mothers (mean age 39.7 years) generalized expectancies, mothers'self-reported parenting practices and their children's optimism, pessimism, and depressive symptoms. A community sample of 81 children (aged 8-12 years) and their mothers participated. Questionnaire were used to assess four parenting dimensions (control, structure, support, and autonomy granting), as well as mothers' and children's' optimism, pessimism, and depressive symptoms. Results showed that maternal
pessimism correlated with child pessimism and that maternal depressive symptoms correlated negatively with child optimism. Multiple regressions indicated that mothers who were moderately controlling had children who showed the most optimism, whereas those who allowed their children little autonomy in problem solving had children with the highest level of depressive symptoms.

According to Scheier and Carver (2000), optimists are people who expect good things to happen to them; pessimists are people who expect bad things to come their way. Optimists and pessimists differ in several ways that have a big impact on their lives. They differ in how they approach problems and challenges in life, and they differ in the manner- and the success with which they cope with adversity (Scheier and Carver, 2000).

According to Scheier and Carver (2000), as is always true in considering heritability, there remains a question about whether optimism is itself heritable, or whether it displays heritability because it is closely related to some other aspect of biologically based temperament. Optimism relates both to Neuroticism and to extraversion and both of these qualities are known to be genetically influenced (Watson, et al., 2002). Although it appears that optimism and pessimism are distinguishable from these temperaments, it may be that the observed heritability of optimism is a product of these associations.

Another potential influence on having an optimistic versus pessimistic outlook on life is early childhood experiences. Many theories maintain that early childhood is an important time in the formation of personality. For example, Erikson’s well-known theory of personality development holds that infants who experience the social world as predictable develop a sense of "basic trust," whereas those who experience the world as unpredictable develop a sense of "basic mistrust." These qualities aren’t all that different from the general sense of optimism and pessimism (Scheier and Carver, 2000).
A good deal of earlier research also indicated that dimension of optimism, and differential coping styles of optimists and pessimists play a major role in physical and mental health outcomes.

Scheier and Carver (1985) report the findings of a project investigating whether dispositional optimism acts as a buffer against stress. They found that optimism positively correlated with indications of active coping with elaboration or complexity of coping strategies, and with the seeking of social support. Optimism was negatively correlated with focus on emotion and emotional expression and with disengagement from the goal. It is of interest that the positive association between optimism and social support was not explicitly predicted. It is indeed possible to expect that pessimists, rather than optimists should seek social support, since due to their expectancies they would fear failure and seek social support.

Plomin et al., (1992) opined that although the power of positive thinking has been part of folk psychology since Peale’s (1956) popular book, only recently has optimism been given serious consideration in research. Optimism and pessimism, defined in terms of positive and negative generalized outcome expectancies (Scheier and Carver, 1987), are not encompassed by related constructs such as internal – external control, self-esteem, and alienation (Scheier and Carver, 1987), although they are related to other self regulatory theories such as attributional style (Abramson, et al., 1978) and self efficacy (Bandura, 1997). In addition to their status as overlooked dimensions of personality, optimism and pessimism merit special attention because they appear to predict mental and physical health variables (Peterson, et al., 1988; Scheier and Carver, 1987; Seligman, 1991; Taylor, 1989).

Aspinwall and Taylor (1992) assessed optimism and coping in a group of students entering college and assessed well-being three months later. In this case, the beneficial effects of optimism appeared
to operate at least in part through differences in both active coping and avoidance coping.

Goodman et al., (1995) examined the extent to which optimism, knowledge, attitudes and beliefs predicted use of HIV (human immunodeficiency virus) testing services by 124 at-risk female adolescents. Optimism scores were not associated with HIV-related knowledge, perceived risk, self-efficacy, condom expectations, or most risky behaviors, including higher levels of recent unprotected intercourse.

According to Raikkonen et al., (1999) a relative paucity of data exists bearing on whether pessimism and optimism, either as a bipolar trait or as two independent dimensions, lead people to experience different physical health consequences in everyday stressful situations. After coronary by-pass surgery, optimists have been shown to recover more quickly from surgery and to have less severe anginal pain than pessimists. Also, optimists have been shown to report fewer physical health complaints than pessimists (Robbins, et al., 1991; Scheier and Carver, 2000). Conversely, it has been shown that pessimists tend to display greater diastolic blood pressure (DBP) reactivity to a laboratory stressor (Williams, et al., 1990). In the only study of physical health that examined optimism and pessimism separately, pessimistic cancer patients were more likely to die during the follow-up than their less pessimistic counterparts (Schulz, et al., 1996). Optimism was unrelated to survival.

According to Raikkonen et al., (1999) ambulatory blood pressure (BP) is an important physical health outcome. Average ambulatory BP is more closely associated with target-organ damage than are casual measures obtained in clinical assessments. Raikkonen et al., (1999) tested the hypothesis that pessimists, as defined by high scores on the Life Orientation Test (LOT) Scheier and Carver, (1985), would experience elevated ambulatory BP throughout the day even if they
were normotensive and in good health. Raikkonen et al., (1999) also evaluated the association of Life Orientation Test pessimism and optimism subscales separately. In the study, ambulatory BP was assessed approximately every 30 minutes during waking hours on 2 work days and 1 nonworkday in 100 normotensive adults. At the time of each BP measurement, participants completed a diary about other possible determinants of BP (e.g. physical activity, posture, and caffeinated beverage intake).

Raikkonen et al., (1999) tested whether dispositional measures of optimism, pessimism, and anxiety affected ambulatory blood pressure (BP) and mood and whether any cardiovascular effects of dispositions were moderated by mood. Pessimistic and anxious adults had higher BP levels and felt more negative and less positive than did optimists or low anxious adults throughout the monitoring. The few times that optimists did feel negative were associated with levels of BP as high as those observed among pessimists or anxious individuals, regardless of the mood. To the extent that trait anxiety measures Neuroticism, these findings suggest that Neuroticism is directly related to health indicators rather than simply to illness behavior. Furthermore, the results suggest that pessimism has broad physiological and psychological consequences.

Brissette, et al., (2002) investigated the extent to which social support and coping account for the association between greater optimism and better adjustment to stressful life events. College students of both genders completed measures of perceived stress, depression, friendship network size, and perceived social support at the beginning and end of their 1st semester of college. Coping was assessed at the end of the 1st semester. Greater optimism, assessed at the beginning of the 1st semester of college, was prospectively associated with smaller increases in stress and depression and greater increases in perceived social support (but not in friendship network size) over the course of
the 1st semester of college. Mediational analyses were consistent with a model in which increases in social support and greater use of positive reinterpretation and growth contributed to the superior adjustment that optimists experienced.

Schneider (2001) defined optimism, not as a function of causal attributions, but as a general disposition to expect good outcomes. They found that optimists reported fewer physical symptoms, better health habits, and better coping strategies. Even among a group of women who had experienced the recent bad outcome of being diagnosed with breast cancer, (Carver, et al., 1993). The authors found that those with an optimistic personality experienced less distress, engaged in more active coping and were less likely to engage in avoidance or denial strategies.

The mechanisms linking optimism to outcomes may vary according to the type of optimism in focus. For example, one of the striking correlates of optimism is good health (Peterson, 1988). This link seems to reflect several different pathways, including immunological robustness (Scheier et al., 2001), absence of negative mood and health-promoting behaviour (Peterson, et al., 1998). The big-versus-little optimism distinction may help understand which pathways are involved in given instances of well-being. The trajectory of a severe illness such as AIDS or cancer may be better predicted by big optimism working through the immune system and mood, whereas the onset of disease and the likelihood of traumatic injuries may be more influenced by little optimism working through behavior and concrete lifestyle choices (Peterson, et al., 1998).

According to Peterson (2000) research by a number of psychologists has documented diverse benefits of optimism and concomitant drawbacks of pessimism. Optimism, conceptualized and assessed in a variety of ways, has been linked to the positive mood and
good morale; to perseverance and effective problem solving; to academic, athletic, military, occupational and political success; to popularity; to good health; and even to long life and freedom from trauma. Pessimism in contrast, foreshadows morbidity and mortality. These lines of research are surprisingly uniform, so much so that an optimism bandwagon has been created, within psychology as well as the general public. One may like to promote among the young and how pessimism can be reversed among the old (Peterson, 2000).

One early study (Carver and Scheier, 2000) of the effect of optimism on emotional well-being examined the development of depressed feelings after childbirth. Optimism related to lower depression symptoms at the initial assessment. More important, optimism predicted lower levels of depressive symptoms post-partum, even when controlling for the initial levels. Thus, optimism seemed to confer a resistance to the development of depressive symptoms after having a baby (Carver and Scheier, 2000).

According to Carver and Scheier (2000) optimists experience less distress than pessimists when dealing with difficulties in their lives. Is this just because optimists are more cheerful than pessimists? Apparently not, because the differences often remain, even when statistical controls are incorporated for previous levels of distress. There must be other explanations. Do optimists do anything in particular to cope that helps them adapt better than pessimists? Many researchers are now investigating this possibility as a potential mechanism through which optimism confers psychological benefits. The coping strategies that optimists and pessimists tend to use may help them deal better with stress (Scheier and Carver, 2000).

According to Carver and Scheier (2000) differences in coping methods used by optimists and pessimists have been found in a number of studies. One early project (Watson et al., 2002) asked
undergraduates to recall the most stressful event that had happened to
them during the previous month and complete a checklist of coping
responses with respect to that event. Optimism related positively to
problem focused coping, especially when the stressful situation was
perceived to be controllable. Optimism also related to the use of positive
reframing and (when the situation was perceived to be uncontrollable)
with the tendency to accept the reality of the situation. In contrast,
optimism related negatively to the use of denial and the attempt to
distance oneself from the problem.

These findings provided the first indication that optimists not only
use problem-centered coping, but also use a variety of emotion-focused
coping techniques, including striving to accept the reality of difficult
situations and putting the situations in the best possible light. These
findings hint that optimists may enjoy a coping advantage over
pessimists, even in situations that cannot be changed.

According to Carver and Scheier (2000), it is particularly
noteworthy that optimists turn towards acceptance in uncontrollable
situations, whereas pessimists turn more to the use of active attempts
at denial. Although both tactics seem to reflect emotion focused coping,
there are important qualitative differences between them that may, in
turn, be associated with different qualities of outcomes. More
concretely, denial (the refusal to accept the reality of the situation)
means attempting to adhere to a worldview that is no longer valid. In
contrast, acceptance implies a restructuring of one’s experience so as
to come to grips with the reality of the situation that one confronts.
Acceptance thus may involve a deeper set of processes, in which the
person actively works through the experience, attempting to integrate it
into an evolving world-view.
Coping Tendencies of Optimists and Pessimists

<table>
<thead>
<tr>
<th>Optimists</th>
<th>Pessimists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information seeking</td>
<td>Suppression of thoughts</td>
</tr>
<tr>
<td>Active coping and planning</td>
<td>Giving up</td>
</tr>
<tr>
<td>Positive reframing</td>
<td>Self-distraction</td>
</tr>
<tr>
<td>Seeking benefit</td>
<td>Cognitive avoidance</td>
</tr>
<tr>
<td>Use of humor</td>
<td>Focus on distress</td>
</tr>
<tr>
<td>Acceptance</td>
<td>Overt denial</td>
</tr>
</tbody>
</table>

In describing the manner in which optimists and pessimists cope with adversity, several other studies are worth noting. These studies don’t deal with coping per se, but they make points that are closely related to the points Carver and Scheier (2000) made regarding coping. Some of these are studies of proactive processes, processes that promote good health and well-being. The reasoning behind the studies is that people who are optimistic about their personal future may take active steps to ensure the positive quality of that future. This behavior would be much the same as engaging in problem-focused coping activities, except there’s no particular stressor threatening the person. The “problem” in this case is simply the problem of ensuring good health and well-being, no matter what circumstances might arise in the future (Compas et al., 2001).

Other studies have examined the health-related habits reported by groups of people with no particular salient health concerns. At least two such projects found associations in which optimists reported more health-promoting behaviors than pessimists (Carver and Scheier 2000). Taken together, the various studies suggested that optimism is associated with behaviors aimed at promoting health and reducing health risk (Carver and Scheier, 2000).
Another set of studies by Carver and Scheier (2000) to consider in this context represent the reverse of the proactive effort at establishing and maintaining well-being. Optimists are characterized throughout as being persistent in the attempts to reach desired goals. This includes persistence in coping with the onset of serious adversity, and it includes active efforts to promote well-being even apart from adversity. People who are pessimistic are less likely to display such persistence. There is, in fact, considerable evidence that pessimists engage in behaviors that have adverse consequences for well-being, that the tendency to give up can have serious— even deadly— consequences for well being (Carver and Scheier, 2000).

According to Scheier and Carver (2000) Optimists are people who hold generalized positive expectations for the future. They expect good things to happen to them, not bad things. Pessimists are just the reverse. They expect to miss out on the good things in life and experience the things that are bad. Research suggests that individual differences in optimism and pessimism may play an important role in the manner in which people react to stressful circumstances which influences their health.

Dozens of studies have been conducted examining the relationship among optimism, pessimism, and distress among groups of people undergoing adversity of one type or another (Steiner et al., 2000).

The results of these various studies all point in the same direction: Optimistic persons experience less distress during times of adversity than pessimists.

DeNeve and Cooper (1998) conducted a study of 103 men and 120 women and found that optimism correlated positively with Extraversion, but it was also correlated negatively, and more strongly, with Neuroticism.
An optimistic outlook has been associated with less distress, better quality of life, better health outcomes, and lower diastolic blood pressure reactivity in stressful situations than a more pessimistic style (King, et al., 1998).

According to Plomin et al., (1992) although recent research suggests links between optimism and mental health, little is known about the genetic and environmental origins of these links or of optimism itself. The Life Orientation Test of optimism and pessimism and various measures of self-reported mental health (depression, life satisfaction, paranoid hostility, and cynicism) were administered to over 500 same-sex pairs of middle-aged identical and fraternal twins, half of whom were reared together and half adopted apart early in life. Twin/adoption analyses yield significant heritability estimates of about 25% for both optimism and pessimism; shared rearing environmental influence was also significant for optimism but not for pessimism. Both optimism and pessimism contributed independently to the prediction of depression and life satisfaction; pessimism but not optimism predicted paranoid hostility and cynicism. These associations diminished little when Neuroticism was controlled. Multivariate genetic analysis of the multiple correlations for the mental health variables suggest that genetic factors contribute appreciably to associations between optimism/pessimism and mental health (Plomin et al., 1992).

According to Jessor et al., (1998) there is much speculation about why adolescents behave in seemingly reckless risky ways. Risk perception and especially the perception of invulnerability have been examined as factors that play a part. The belief that no harm will ever come to oneself is discussed by some (Weinstein, 1989) as optimistic bias that must be corrected, and by others as adolescent egocentrism. Both sides view such optimism as maladjustment. Holger’s study expands the scope of the previous work in that it considers the positive aspects of perceptions of invulnerability.
Perceived vulnerability is thought to be an important factor in avoiding the consequences of risk behavior and is a key concept in such models of health behavior as the health belief model (Jessor et al., 1998) and health protection motivation. Educational programs based on such models include programs designed to increase awareness of a particular disease or health problem, and personal perception of the risks attached to particular forms of health-related behavior and one’s susceptibility to their adverse effects. These programs remain among the most widely used methods of health promotion, despite equivocal evidence of their effectiveness (Jessor et al., 1998). They are aimed at reducing risk-taking behavior. Difference in risk perception exist between pessimists and optimists.

According to Weinstein (1989), individuals with optimistic bias think that they are less likely than the average person to experience health problems from any cause. For example, when college students were asked to estimate their own chances of getting heart disease, compared with those of other students of the same gender at their college, they rated their own risk as significantly lower than those of others (Weinstein, 1989). Such findings are often interpreted as expressions of adolescent egocentrism, very generally an overall focus on self as a result of a lack of differentiation in some aspect of subject-object interaction (Piaget, 1954). Bergman and Scott (2001) reported teenagers to be less optimistic than their parents about their comparative chances of avoiding illness and misfortune. Moreover, those who took the greatest risks were the least likely to exaggerate their own invulnerability to harm.

Optimism is a consequence of cognitive processes, including the egocentric expectation that the future will be positive, and belief in one’s ability to control the environment. There is sufficient evidence of a link between such belief and optimistic bias leading to reckless behavior and teenagers (Harris 1991).
Scheier and Carver (1985) designed other models to produce protective behaviors. Examples are self-efficacy, optimism, hardiness, and sense of coherence. They take into account underlying psychosocial and personality factors that may determine behavior in regard to health and health care. Perceived invulnerability, optimistic bias, and egocentrism are conceptually similar to optimism (Scheier and Carver, 1985). A generalized positive or negative expectancy is part of an optimistic or pessimistic disposition.

Optimistic persons, as we have defined them, should be more likely than pessimistic persons to conclude that the impediments facing them can be overcome (Scheier and Carver, 1985).

Byrne and Mazanov (1999) studied Swiss teenagers, aged 16 to 17 years, who were asked about their past drug use, their intended drug use, their optimism about their future health, their negative emotions, and their well-being. On the basis of their self-reports, they were divided into 3 types of drug users: nonusers, experimenters, and frequent users. Compared with nonusers, experimenters and frequent users reported low optimism and more negative feelings. Females reported more negative feelings and less psychological well-being than did males, but the genders did not differ regarding optimism. Logistic regression demonstrated that optimism about future health was a protective factor for the intention to use drugs. Students who perceived themselves as less vulnerable to harm had in the past not used drugs and intended not to accept drugs when given the occasion.

Taylor et al., (2000) said that psychological beliefs such as optimism, personal control, and a sense of meaning are known to be protective of mental health. The question is – are they protective of physical health as well? The authors present a program of research that has tested the implications of cognitive adaptation theory and research on positive illusions for the relation of positive beliefs to disease progression among men infected with HIV. The investigations have
revealed that even unrealistically optimistic beliefs about the future may be health protective. The ability to find meaning in the experience is also associated with a less rapid course of illness. Taken together, the research suggests that psychological beliefs such as meaning, control, and optimism act as resources, which may not only preserve mental health in the context of traumatic or life-threatening events but be protective of physical health as well (Taylor et al., 2000).

One of the problems that health educators have to deal with when they are trying to change an individual’s behaviour is one’s unrealistic optimism about our health. A number of studies, for example, Weinstein (1989) have asked people to rate their personal risk of developing various disorders compared to people like them. Individuals usually rate their chances of illness as less than that of other people. The problem with this optimism is illustrated in a study by Banyard (2001) of students at Oxford University who judged their own risk of contracting AIDS to be less than that of their fellow students. This was even true to students who were taking part in high risk behaviours such as unprotected penetrative sex, and sex with bisexual partners, intravenous drug users, or prostitutes. So, why were they so optimistic about our health? Weinstein suggested four cognitive factors that affect this optimism:

i) people tend to believe that if a problem has not appeared yet, then it is unlikely to develop in the future.
ii) people tend to think that personal action can prevent the problem
iii) people believe that the problem is rare
iv) people have little or no experience of the problem

These cognitive factors do not provide a logical framework for making judgments about personal risk, but people do not operate on the basis of logic. On the whole, this optimism is no bad thing since it prevents one from developing a maudlin preoccupation with illness, but
it does mean that one is resistant to health messages about the dangers of one’s lifestyle (Banyard, 2001).

Dougall et al., (2001) examined the effects of optimism following traumatic stress and pathways through which optimism may act. Rescue and recovery workers at the crash site of US Air Flight 427 (n=159) were studied 2,6,9 and 12 months after the crash to examine optimistic outlook, social support, coping and stress. As predicted, a more optimistic disposition was associated with less self-reported distress, less use of avoidant and wishful thinking coping, and greater availability of social support. Contrary to expectations, coping did not account for the relationships observed between optimism and stress responding. Social support explained some of the effects of optimism on coping and stress, but these mediational effects varied over time. Findings suggest that optimism affects stress and coping directly and indirectly by affecting how much social support is available.

Dougall et al., (2001) tested the hypotheses concerning the relationships between optimism and coping and found support for them. Consistent with previous research, optimism was positively associated with the use of problem-focused coping. Similarly, optimism was negatively related to wishful-thinking coping.

According to Dougall et al., (2001) optimism was positively associated with seeking-social support coping. Use of this coping strategy was relatively stable, just as the optimism construct was. As predicted, avoidance coping was positively related to distress and negatively related to optimism.

Dougall et al., (2001) also suggest that social support is an important factor in the relationship between optimism and coping, and between optimism and stress. In this sample, optimism and support were positively related. While this finding is not new, previous research has not fully examined the possibility that social support might explain some of optimism’s relationship with coping and stress. Perceived social support predicted similar profile of coping and stress responses as optimism and accounted for some of its effects. Optimists have more
social support and consequently turn to supportive others and rely less on wishful fantasies initially as ways of dealing with stress. Additionally, optimistic beliefs and perceptions of support may work in concert to determine overall distress. Both optimism and social support have independent effects when distress is high or low.

Eiser et al., (2001) reported studies in which students made comparative assessments of their own and others’ prospects of future examination performance, either by rating themselves in comparison to “typical others” (Self- other focus) or by rating typical others” in comparison to themselves (other –self focus). Participants also provided separate (absolute) estimates for self and others in terms of an evaluative scale and predicted grades. In both studies, under self- other focus, comparative estimates correlated positively with self-estimates but not with other-estimates: under other-self focus, comparative estimates correlated positively with self-estimates and negatively with other-estimates. Eiser’s findings suggest that unrealistic optimism and better-than-average effects previously found with self-other comparisons primarily reflect self-evaluations rather than the use of a normative standard. Comparative judgments also showed more relative optimism, or positively, for the self under self – other than under other-self focus. This is applied to predictions of exam performance (both studies), ratings of behaviour relevant to exam performance (Study 1) and predictions of future outcomes in the domains of health, achievement and personal relationships (Study 2). This tendency for greater optimism under self-other focus was more marked for positive than for negative outcomes (Eiser et al. 2001).

**HAPPINESS / SUBJECTIVE WELL-BEING AND TEENAGE HEALTH**

Traditionally psychologists and researchers have measured Psychological and Physical Well Being as the absence of pathology. In more recent years, the focus of Well-Being has shifted to measurement
of presence of health or individual's subjective evaluation of their lives in general, i.e. see their quality of life, Subjective Well Being (SWB), Happiness and Satisfaction with Life (SWL) (Diener, 1984).

This is because, in recent years, psychologists have become increasingly concerned with the positive end of the psychological well-being spectrum. Instead of focusing solely on the factors that lead to disorders such as depression and anxiety, researchers have begun to examine the antecedents and consequences of happiness, self-esteem, optimism, and other indicators of positive well-being.

These constructs are sometimes used interchangeably e.g. life satisfaction, Subjective well being and Happiness (Diener, 1984). Most of the research has broken down the broader construct of SWB into cognitive and affective components (Diener and Larsen, 1993). The cognitive component usually pertains to the rational, intellectual evaluation of one's life satisfaction. The affective/ emotional component usually involves the measurement of happiness in same way.

A person's evaluation of his or her life may be in the form of cognitions (e.g., when a person gives conscious evaluative judgments about his or her satisfaction with life as a whole, or evaluative judgments about specific aspects of his or her life such as recreation). However, an evaluation of one's life also may be in the form of affect (people experiencing unpleasant or pleasant moods and emotions in reaction to their lives). Thus, a person is said to have high SWB if she or he experiences life satisfaction and frequent joy, and only infrequently experiences unpleasant emotions such as sadness and anger. Contrariwise, a person is said to have low SWB if he or she is dissatisfied with life, experiences little joy and affection, and frequently feels negative emotions such as anger or anxiety. The cognitive and affective components of SWB are highly interrelated (Diener et al., 2003).
There are three primary components of SWB: satisfaction, pleasant affect, and low levels of unpleasant affect. Subjective well-being is structured such that these three components form a global factor of interrelated variables (Diener, 1984).

People’s moods and emotions reflect on-line reactions to events happening to them. Each individual also makes broader judgments about his or her life as a whole, as well as about domains such as marriage and work. Thus, there are a number of separable components of SWB: Life Satisfaction (global judgments of one’s life), satisfaction with important domains (e.g., work satisfaction), positive affect (experiencing many pleasant emotions and moods), and low levels of negative affect (experiencing few unpleasant emotions and moods).

Lucas, et al., (1996) examined the convergent and discriminant validities of well-being concepts using multitrait-multimethod matrix analyses. Analyses showed that (a) life satisfaction is discriminable from positive and negative affect, (b) positive affect is discriminable from negative affect, (c) life satisfaction is discriminable from optimism and self-esteem, and (d) optimism is separable from trait measures of negative affect.

Cowen (1994) reported that five main pathways to wellness have been identified: (a) forming wholesome early attachments; (b) acquiring age-appropriate competencies; (c)exposure to settings that favor wellness outcomes; (d) having the (empowering) sense of being in control of one’s fate; and (e) coping effectively with stress.

Diener and Diener (2000) also opined that during the past decades, psychology has been a discipline that focussed on problems such as depression, anxiety, and other maladies. Psychologists have not been very concerned with the positive – with helping people to be happier, more fulfilled, more altruistic, and so forth. Thus, a new direction in which psychologists can expand their activities is in helping people live more rewarding lives. Although the image of the good life is
bound to vary somewhat across cultures, it will probably always to some degree include close relationships, responsibilities to one’s community, and enjoyment of one’s life. The positive psychology movement started in the U.S.A. (Seligman and Csikszentmihalyi, 2000) is devoted to increasing the scope of psychological research and practice so that it focuses not just on problem alleviation, but also on helping people to enhance their lives, for example by experiencing greater SWB. The idea here is that we can aid people in having happier and more rewarding marriages and families, work and recreation, and friendships, and not just strive to solve problems.

According to Diener and Diener (2000) Subjective well-being is increasingly important in a democratic world in which we want people to live fulfilling lives as evaluated by themselves, not simply as judged by policy makers, autocrats, or experts. As people in the world come to meet their basic biological needs, they become increasingly concerned with happiness and fulfillment. Thus, it is not surprising that in an international survey of college students, authors found that life satisfaction and happiness were rated as extremely important (Diener and Diener 2000). For example, on a 7-point importance scale, on which 1 was “not at all important”, and 7 was “extraordinarily important”, respondents in India on an average rated life satisfaction at 5.75 and happiness at 5.97. In comparison, money was rated only 4.81, indicating that the Indian respondents believed that happiness and satisfaction were more important than money.

Does Health Influence Happiness? Health is one of the strongest predictors of happiness, especially in the old. Willits and Crider (1988) studied 1,650 individuals aged 50-55 and found that health satisfaction was the strongest predictor of overall satisfaction. Brief, et al., (1993) used an objective measure of health, and found in a longitudinal study that it predicted satisfaction and the absence of negative affect, but failed to predict positive affect.
Sandvik et al., (1993) reported that symptoms of illness are predicted to correlate inversely with well-being because of causal paths in both directions. Evidence from a number of studies suggests that illness makes people less happy however, other studies suggest that the relation between self-reported health and SWB results primarily from unhappy people perceiving more symptoms of illness. Similarly, a high grade point average might correlate with well-being both because it is a valued resource, and also because depressed individuals may function less well academically.

King and Napa (1998) said that a variety of thinkers from a broad range of disciplines have puzzled over what it is that makes a good life. Aspects of the life well-lived that are frequently proposed include the importance of happiness, a sense of purpose, wisdom, creativity, a philosophy of life, achievement, and the experience of love. The ways in which individuals answer the question of what makes a life good are undeniably shaped by history and culture. It is important to note, for instance, that concern for internal states such as happiness and personal fulfillment may be peculiarly Western and modern concerns. Given the importance of culture and history in definitions of the good life, King and Napa (1998) selected three variables that have been the subject of attention and debate in Western notions of “the good life” i.e. happiness, meaning in life, and money.

Aristotle argued that goals are valued only to the extent that they relate, ultimately, to happiness. It has been argued that SWB research has equated happiness with the good life. Research on life goals and wishes confirmed that seeking happiness is a common desire. They found that happiness was a common goal among college students. “Enjoyment” has also been identified as a central dimension of human values. The wish for happiness was a “top three” wish among participants in a study by King and Napa (1998). Clearly people want to be happy.
Consistently, meaning and happiness determined the desirability of a life. Wealth was largely irrelevant to judgments of the good life by college students and was of only limited relevance for community adults (King and Napa, 1998).

In the recently revived research in the area of subjective well being (SWB: often used interchangeably with the term happiness), researchers now believe that happiness is composed of three related components: positive affect, absence of negative affect, and satisfaction with life as a whole. Happiness is not merely a transient emotional state, short lived and completely dictated by environmental events; rather, it is more often conceptualized as a personal trait.

The personality-based approach to well-being holds that happiness is determined primarily by personality factors (Diener and Diener 2000). One form of this position is called the "set-point perspective," which holds that personality dispositions are the most potent influences on average levels of happiness. One version of this perspective asserts that individual differences in well-being are highly heritable, particularly with regard to positive and negative affect (Mroczek and Kolen, 1998).

Self-esteem covaries with SWB, although this relation is stronger in individualistic societies where the "Self" stands out as more important (Diener & Diener, 1995). In collectivist cultures self-esteem and life satisfaction are typically related, but not so strongly as in individualistic Western nations. Not surprisingly, optimism is related to SWB in the United States (Lucas et al., 1996). Similarly, positive illusions (i.e., Self-aggrandizement, unrealistic optimism, and exaggerated perceptions of control) are common among North Americans and function as coping mechanisms to restore and maintain positive psychological and physical health of Americans. However, recent cross-cultural studies found that such positive illusions are not common among Asians, suggesting that
self-enhancement and optimism may not lead to higher SWB in all cultures (Diener et al., 1997).

During the next stage in SWB research, ushered in by Diener's (1984) call for more psychological and theoretical research in this field, investigators carefully examined several conceptual models for explaining SWB. One theoretical approach emphasized temperament and personality as important underpinnings of whether people are happy. For example, Costa and McCrae (1980) proposed that two major personality traits, extraversion and neuroticism, underlie people's propensity to react positively or negatively, respectively, to an event. Confirming this hypothesis, Lucas et al., (1996) found that across cultures there is a tendency for extraverts to report more positive emotions. Similarly, Tellegen et al., (1988) concluded that genes account for 40% of the variance in positive emotionality and 55% of the variance in negative emotionality, whereas shared family environment accounts for 22% and 2% of the variance in positive emotionality and negative emotionality, respectively.

According to Diener and Diener (2000) a number of investigators have concluded that inborn temperament is a very important influence on people's long-term level of SWB, although immediate events will move respondents up or down from their baseline.

Two generally oppositional perspectives, that of the person and the environment, form the basis for various models and theories proposed to explain the subjective experience of happiness. Personality models (Costa & McCrae, 1984) are typical examples of the first perspective. Such models conceptualize happiness as a stable trait that depends primarily on personality. This perspective looks to various personality traits to account for an individual's experiences. These models subscribe to the top-down approach and emphasize an individual's innate capacity for happiness.
In their research review, Myers and Diener (1995) reported on the existence of a happiness trait that consists of self-esteem, personal control, optimism, and extraversion. However, by focusing on longitudinal studies, Veenhoven (1994) concluded that happiness is at best moderately stable in the short-term, is sensitive to fortune and adversity, and is not entirely innate. Consequently, the trait analogy is not supported widely by empirical data. However, Lu (1999) contested this statement. Although it seems that personality plays an important role in SWB levels, it is not the only influential factor. In fact, if it were the only influential factor, a person’s level of SWB would remain virtually unchanged over his or her entire lifetime.

According to Lu (1999) life events models are representative of the environment perspective. Such models recognize that some people’s levels of happiness can fluctuate quite substantially over time. As such, these models look to both major positive and negative life events to account for changes in SWB. These types of models are typically bottom-up. As demonstrated in Veenhoven’s (1994) review, happiness does respond to life transitions, both good and bad, especially the major and dramatic ones. However, consistent with the thesis of the adaptational model, only recent life events were found to influence SWB (Myers & Diener, 1995).

As in so many cases of psychological inquiry, a particular behavior or state of mind is most likely produced by a complex interaction between the individual and his or her environment. Previous research, based on the interactionist perspective revealed that both personal and environmental factors are important correlates of happiness (Lu, 1999). Thus, an integrative model of happiness was theoretically constructed and empirically revised. It includes both the direct paths to happiness (e.g. neuroticism, locus of control and social support) and the indirect paths to happiness (e.g. age, gender, and extraversion through social support).
Argyle (1997) concluded that happiness and positive moods influence health, and vice versa. A number of social and personality factors influence health directly, for example by affecting health behaviour or the immune system. These factors also affect health indirectly by influencing happiness and moods. These factors include social relationship, exercise and other aspects of leisure, job status and other aspects of personality.

Wilson (1967) investigated correlates of happiness. Findings replicated successfully showed happiness to be unrelated to wealth of parents, education of parents, IQ, and school success and to be related to (a) health, good social relations, and good family relations (Wilson, 1967). Other studies relate happiness to youth, number of leisure-time activities enjoyed, and time spent in leisure-time activities, optimism, warmth, emotional stability, self-insight, and sociability (Wilson 1967).

Ryff et al. (1995) studied the relationship of happiness with self acceptance, positive relations with others, purpose in life, personal growth, autonomy and environmental mastery. The results revealed that happiness was positively and significantly correlated with self acceptance, positive relations with other, purpose in life, personal growth, autonomy and environmental mastery.

In adults, optimism, self-esteem, and extraversion are several of the personality traits possessed by happy people (Diener, et al., 1997).

In a study by Luo and Shih (1997) perceived sources of happiness among community residents in Kaohstung, Taiwan, and in the West were identified and compared. The authors performed a qualitative analysis to develop a typology and found 9 major categories among 180 reported sources of happiness. They were (a) gratification of need for respect, (b) harmony of interpersonal relationships, (c) satisfaction of maternal needs, (d) achievement at work, (e) being at ease with life, (f) taking pleasure at others’ expense, (g) sense of self-control and self-actualization, (h) pleasure and positive affect, and (i)
health. The results indicated that the Western conception of happiness places greater emphasis on intrapersonal or internal evaluation and contentment, whereas the Chinese conception of happiness places greater emphasis on interpersonal or external evaluation and satisfaction. The Chinese conception of happiness also has unique components, such as being at ease with life.

Lu and Shih (1997) asked subjects – what is meant by happiness? People gave two kinds of answers: (a) often experiencing a positive emotional state such as joy or (b) being satisfied with life as a whole or with parts of it. These are two possible components to happiness. However, happiness is not the opposite of unhappiness, depression, or psychological ill-health, although it is negatively related to those states and has somewhat different causes (Argyle, 1997; Lu and Shih, 1997).

Lu and Shih (1997) also reported some age differences in terms of sources of happiness. The sources of happiness that were mentioned most frequently were pleasure and positive affect for respondents aged 16-20; satisfaction of material needs for those aged 20-30; achievement at work for those aged 30-40; gratification of need for respect for those aged 40-50; and being at ease with life for those older than 50. This pattern of apparent differential importance in sources of happiness corresponds to specific concerns relevant to particular stages in life. However, the importance of family and interpersonal relationships was not affected by age, a finding that is consistent with the Chinese emphasis on the social being.

King and Napa, (1998) examined folk concepts of the good life. Samples comprised of college student (N =104) and community adults (N =264). The results of these studies suggest that the folk concept of the good life converges with the portrait presented in the literature on SWB. Meaning in life and happiness determined the desirability of a life. Wealth was largely irrelevant to the judgment of the good life by college
students and was of only limited relevance for community adults. With regard to moral goodness, the college sample provided some support for the theory of the moral goodness of the suffering individual engaged in meaningful pursuits. However, this sample also tended to see salvation in the life that was characterized by meaning, happiness, and wealth. In the community sample, such an interaction did not emerge. For both samples, happiness and meaning tended to affect ratings of moral goodness. A final independent variable to be considered is money. Surprisingly, beyond being able to afford life's basic needs, additional income has little effect on happiness (King and Napa 1998).

Second, negative life events were found to be detrimental to overall happiness, whereas positive life events were related to life satisfaction, one of the three components of happiness. If the “whole” and the “part” have different predictors, can they still be interchangeable? The answer seems to be no. Although overall happiness and life satisfaction were always significantly correlated, the strength of the relationship was at the most moderate (average $r = .47$), with a small, overlapping variance (approximately 22% in this study). A balanced conclusion seems to be that although there is a recursive relationship between overall happiness and life satisfaction, it is nonetheless inappropriate to adopt life satisfaction as the sole indicator of the SWB construct. More caution should also be exercised in synthesizing research pertaining to life satisfaction with research covering the whole of the SWB construct (Myers and Diener, 1995).

Using a longitudinal data set, Lu (1999) analyzed an integrative model of happiness, which incorporated personal factors (demographics, extraversion, neuroticism, and locus of control) and environmental factors (life events and social support). A secondary purpose was to clarify the relationship between overall happiness and life satisfaction. Results revealed that social support predicted overall happiness, and positive life events predicted life satisfaction.
Furthermore, there was a consistently strong bi-directional relationship between overall happiness and life satisfaction.

According to Fleeson et al., (2002) the between persons extraversion positive affect relationship means that more extraverted individuals are happier than are more introverted individuals, on an average. Researchers have demonstrated this relationship by obtaining reports of overall or dispositional extraversion as well as of overall positive affect. Resulting correlations typically varied from .10 to .70 (Diener et al., 2003).

Mahon and Yarcheski, (2002) examined a set of variables representing enabling mechanisms vis-à-vis a set of variables representing personality characteristics in relation to happiness in early adolescents. Using hierarchical analyses of sets, the study found that the enabling mechanisms set explained more variance in happiness when entered first (65%) or second (22%) than did the personality characteristics set when entered first (50%) or second (7%) in the analyses.

Steel and Ones (2002) reported that much of the long-term happiness appears to be due to stable and internal causes. Continuing their review, Diener et al., (2003) indicated personality traits, viz, being stable and internal themselves, influence SWB. Several traits have been connected to individual happiness, but the strongest and most consistent findings are for just two personality dimensions: Extraversion and Neuroticism. Extraversion is associated with increased happiness, and Neuroticism is associated with decreased happiness.

According to Diener et al., (2003) one approach to SWB based on inherent and universal human needs is the Self-Determination Theory of Deci & Ryan (2000). This theory posits three basic psychological needs —autonomy, competence, and relatedness — and predicts that fulfillment of these needs is essential for well-being and happiness. Ryan and their colleagues found that fulfillment of these needs, which they refer to as
“intrinsic,” needs such as autonomy, competence, and relatedness, are related to SWB in diverse nations such as the United States, Bulgaria, Germany, South Korea, and Russia. It seems contradictory, of course, to suggest that there are both universal and culture-specific determinants of SWB. The empirical challenge is to identify these two types of variables and determine the degree to which universal needs are channeled by the culture.

SATISFACTION WITH LIFE AND TEENAGE HEALTH

Life satisfaction refers to an individual’s personal judgment of well-being and quality of life based on his or her own chosen criteria (Diener, 1984). For more than 20 years, the study of psychological well-being has been guided by two primary conceptions of positive functioning. One formulation, distinguished between positive and negative affect and defined happiness as the balance between the two. The second one emphasized Life Satisfaction as the key indicator of well-being.

Life satisfaction and self-esteem are variables that both represent global evaluations: in the former case an evaluation of a person’s entire life and in the latter case a judgment of oneself. Life satisfaction is a construct that is central to the subdiscipline of SWB.

According to Ryff and Keyes (1995), a conception that has gained prominence among sociologists is one, which emphasizes life satisfaction as the key indicator of well-being. Viewed as a cognitive component, life satisfaction was seen to complement happiness, the more affective dimension of positive functioning. Still other studies parsed well-being according to global questions about overall life satisfaction and domain-specific questions about work, income, social relationships and neighborhood (Diener and Diener 1995).
Ryff and Keyes (1995) said that to understand the nature of wellness, descriptive studies have focused on age and gender profiles. They compared young (18-29 years old), midlife-aged (30-64 years old), and old-aged (65 years old or older) adults and found incremental age profiles for Environmental Mastery and Autonomy (particularly from young adulthood to midlife), decremental age profiles for Purpose in Life and Personal Growth (particularly from midlife to old age), and no age differences for Self-Acceptance and Positive Relations With Others. Most of these patterns were replicated in another study involving the same three age groups. In both investigations, women scored significantly higher than men on Positive Relations With Others and Personal Growth, with subsequent studies replicating these sex differences (Ryff and Keyes, 1995).

A positive correlation between age and life satisfaction has surfaced in several studies. Other research has indicated that younger people are more satisfied with life than are older people. These contradictory findings seem to be due to differences in the samples. However, the majority have found virtually no age effects (Headey & Wearing, 1991).

Diener (1984) found that the degree of perceived freedom of choice or control in a person’s life is consistently related to happiness and leads to satisfaction with life as a whole. Cunningham (1988) also found a significant positive relationship between perceived control and life satisfaction for men and women.

Hong and Kopoulous (1994) administered a self-report questionnaire to 1,749 adult Australians between 17 and 40 years old to examine the predictive values of self-esteem, depression, locus of control, trait anger, religiosity, psychological reactance, and age in relation to life satisfaction. Results of independent regression analyses showed that all but psychological reactance were significant predictors of life satisfaction. In the stepwise analysis, self-esteem, depression,
trait anger, locus of control, and religiosity were significant, and together accounted for 26.3% of the total variance of life satisfaction. In both the stepwise and independent analyses, self-esteem and depression affected levels of satisfaction more than any other variables.

Hong and Kopoulous (1994) said that previous research has revealed that internal locus of control is consistently related to greater life satisfaction, higher subjective well-being and happiness (Diener, 1984). Furthermore, some researchers have demonstrated that locus of control is a powerful predictor of life satisfaction, with its predictive power ranging from 4.6% to 23%. On this evidence summarized here, authors expected a positive association between internality, life satisfaction and health.

As little research has been conducted directly relating trait anger to life satisfaction, concepts such as state anger and hostility were included in the study. There seem to be two functions of anger in relation to life satisfaction. The positive function considers anger as an adaptive and carthartic emotion, as a positive basis for communication, or as an energizing affect in life. The negative aspect of anger has generated opposing effects. For instance, hostility produced a low level of life satisfaction among young adults, and Diener (1984) found that low anger arousal was related to high well-being for university students of both sexes. The concepts included in the study were more closely linked to state anger than to trait anger, but because the two are highly related, authors expected an inverse relationship between trait anger and life satisfaction in their study.

The satisfaction with life scale (SWLS) was developed in the United States as a multi-item scale for the overall assessment of life satisfaction as cognitive judgmental process. Neto (1995) reported that satisfaction with life scale (SWLS) scores showed to be predictably associated with, loneliness, social anxiety, shyness, self-concept and physical attractiveness among adolescents.
Diener and Diener (1995) said that past research in the West has shown that self-esteem is a strong predictor of life satisfaction. They studied cross-cultural correlates of life satisfaction and self-esteem. College students in 31 nations (N = 13,118) completed measures of self-esteem, life satisfaction, and satisfaction with specific domains (friends, family, and finances). The authors assessed whether cross-cultural variations in the strength of associations were related to societal dimensions including income and individualism. At the individual level, self-esteem and life satisfaction were correlated .47 for the entire sample. This relation, however, was moderated by the individualism of the society. The associations of financial, friend, and family satisfactions with life satisfaction and with self-esteem also varied across nations. Financial satisfaction was a stronger correlate of life satisfaction in poorer countries. It was found that life satisfaction and self-esteem were clearly discriminable constructs. Satisfaction ratings, except for financial satisfaction, varied between slightly positive and fairly positive.

Caprara et al. (2002) performed two experiments to examine current and earlier personal determinants of subjective well-being in a large group of 592 Italian adolescents (aged 15-19 years). As a premise to both studies, self-esteem, life satisfaction and optimistic orientation towards life were posited as important ingredients of subjective well-being. In the first experiment, confirmatory factor analysis proved the existence of a common second order factor underlying self-esteem, life satisfaction and optimistic orientation towards life.

Vitterso et al. (2002) reported that Satisfaction With Life (SWL) is closely related with quality of life and reported a positive correlation between SWL and national wealth (GNP). Induced it is interesting to probe the satisfaction with life of teenagers in relation to gender and other psychosocial correlates.